Physicians' Newsletter

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Guidelines and Protocols Advisory Committee (GPAC)– Update

Clinical practice guidelines in BC are produced by the Guidelines and Protocols Advisory Committee (GPAC). GPAC is an advisory committee of the Medical Services Commission (MSC) and is jointly supported by the BC Medical Association and the Ministry of Health. In August 2007, GPAC welcomed new co-chair, Dr. Bakul Dalal. The guidelines and protocols provide practical and easy-to-follow evidence-based advice, specific to BC practitioners, to assist with effective patient care.

Over the past six months GPAC released or revised the following clinical practice guidelines and protocols:

New Releases

- Mammography – Protocol for the Use of Diagnostic Facilities
- Cognitive Impairment in the Elderly
- Cardiovascular Disease – Primary Prevention

Revisions

- Hypertension – Detection, Diagnosis and Management
- Heart Failure Care
- Gallstones – Treatment in Adults
- Chronic Obstructive Pulmonary Disease (COPD)

GPAC activities during the past six months

- Participated in the St. Paul's Hospital CME Conference for Primary Care Physicians and the BC College of Family Physicians Annual Scientific Assembly

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GPAC update continued from page 1

- Updated the new BCGuidelines.ca web site, with all 52 guidelines and protocols now online, in PDF or HTML.
- Distributed the 2007 Guidelines & Protocols Binder
- Contracted the University of British Columbia, Continuing Professional Development and Knowledge Translation Division to deliver BC guidelines and protocols in a Personal Digital Assistant (PDA) format. Province-wide implementation is anticipated for spring 2008.
- Obtained MSC approval of the *Guideline Evaluation Working Group 2007/08 Evaluation Plan* in preparation for the formal evaluation of existing guidelines and protocols.

Looking ahead

Guidelines and protocols currently under development or in the process of being revised:

- Cardiovascular Disease – Primary Prevention;
- Stroke Prevention and Management;
- Frailty in Older Adults – Early Identification and Management;
- Asthma – Diagnosis and Management;
- Osteoarthritis;
- Osteoporosis;
- Blood Androgens Protocol;
- Prenatal Cytogenetics;
- Anxiety and Depression in Children and Youth;
- Hepatitis B and C;
- Suspected Infectious Diarrhea;
- Genital Specimens – Office and Lab Management;
- Sore Throat;
- Radiology/Diagnostic Imaging;
- Chronic Kidney Disease – Identification, Evaluation and Management of Patients; and
- Chest Pain – Evaluation of Acute Coronary Symptoms.

Copies of the guidelines and protocols, in both HTML and PDF formats, are available online, as well as additional physician and patient information.

Web site: www.BCGuidelines.ca.

For more information:
E-mail: hlth.guidelines@gov.bc.ca

Address:
Guidelines & Protocols Advisory Committee
PO Box 9642 STN PROV GOVT
Victoria BC V8W 9P1

Audit Billing Tip – Group Counselling

The MSC Payment Schedule provides a number of fee items for group counselling such as 00121, 00122, 00313, 00315, etc. The Billing Integrity Program (BIP) has noted a number of billing errors made by physicians regarding provision and billing of these services, such as:

- incorrectly billing 00121, etc. once per patient, rather than once per group, unless the item specifically states "per patient" as is the case with items 00630 through 00670 in the Psychiatry section of the Payment Schedule;
- incorrectly billing 00121, etc. when the service was delegated to a paramedical professional such as a social worker, dietician or psychologist, even though the physician may have observed the session or participated in a lesser role. This has been noted in a variety of non-profit outpatient chronic disease clinics;
- incorrectly billing counselling when the actual activity represented non-physician or uninsured services such as supervised exercise classes, weight loss clinics, etc., and
- failing to create and maintain an adequate medical record on each individual patient seen during a group counselling session.

An unusual pattern of practice with respect to counselling may be noted during routine profile reviews by BIP staff and may be grounds for an on-site audit. Physicians who bill group counselling or similar group fee items are asked to consider the above observations and make necessary changes to their pattern of practice.

Group Counselling – Billing Tip

When a parent attends counselling with a child receiving care, the claim should be billed as a normal counselling visit (fee item 00514) on the child's personal health number (PHN), unless both the child and parent are patients.

When billing fee item 00513 (group counselling for groups of two or more patients) a note record should be included. If fee item 00513 is billed without a note record it will be paid as fee item 00514.

Telemetry Policy

1. Effective June 1, 2007, the "Guidelines for the Use of Telemetry" under Diagnostic Radiology are deleted and replaced with the following:

Definition
Diagnostic Radiology Telemetry: the electronic transmission of radiological images from one site to another for interpretation.

For diagnostic radiology telemetry services to be considered as benefits under the MSP:

- the transmitting and receiving sites must be located within MSC approved and Diagnostic Accreditation Program accredited diagnostic facilities;
- the services are rendered to out-patients; and
- the services are billed in accordance with the Telemetry Billing Guidelines.

2. Effective June 1, 2007, the "Guidelines for the Use of Telemetry" under Nuclear Medicine are deleted and replaced with the following:

Definition
Nuclear Medicine Telemetry: the electronic transmission of nuclear medicine images from one site to another for interpretation.

For nuclear medicine telemetry services to be considered as benefits under the MSP:

- the transmitting and receiving sites must be located within MSC approved and Diagnostic Accreditation Program accredited diagnostic facilities;
- the services are rendered to out-patients; and
- the services are billed in accordance with the telemetry billing guidelines.

3. Effective June 1, 2007, the "Guidelines for the Use of Telemetry" under Diagnostic Ultrasound are deleted and replaced with the following:

Definition
Diagnostic Ultrasound Telemetry: the electronic transmission of diagnostic ultrasound images from one site to another for interpretation.

For diagnostic ultrasound telemetry services to be considered as benefits under the MSP:

- the transmitting and receiving sites must be located within Medical Services Commission approved and Diagnostic Accreditation Program accredited diagnostic facilities;
- the services are rendered to out-patients; and
- the services are billed in accordance with the telemetry billing guidelines.

Real time ultrasound fees may only be claimed for studies performed by telemetry when:

- the facility currently holds a remote site designation from the Medical Services Commission. (Facilities should recognize that once the volume of service justifies full-time radiologist's coverage remote site designation may be removed.);
- the use of telemetry will not negatively affect the existing on-site visit schedules of the radiologists; and,
- the majority of scans will continue to be scheduled when the visiting radiologist is on-site for the purpose of ultrasound supervision.

Telemetry Billing Guidelines

a) Services must be billed by the facility where the image was taken using the practitioner number of the physician who did the interpretation.
b) Facility number field = the facility number of the diagnostic facility where the image was taken.
c) Sub-Facility field
   - the facility number of the diagnostic facility where the image was interpreted.
   - zeros if interpreted at the same site where the image was taken.
d) Service charges (fee items 01200 – 01202) are only billable when a physician is required to travel from home to hospital in order to perform a telemetry service for an outpatient and when the *MSC Payment Schedule* criteria are met.
e) The original site should ensure that only one interpretation is billed to MSP.
f) In those rare cases when a second radiological opinion is requested by the referring physician, a radiologist may bill for the service using fee item 08628, provided a written radiological report is sent to the referring physician.

GP Services Committee Practice Support Program

Advanced Access Scheduling – A Proven Way of Reducing Patient Wait Times for Office Appointments

"Using Advanced Access shifted my attitude from being overwhelmed by patient demands to being able to meet my patients' needs in a timely manner. I've had wonderful feedback from PSP participants who immediately made positive changes in their practices."

Dr. Joanne Larsen, North Shore
GP Champion teaching
Advanced Access

"We have been using Advanced Access in our office since the first PSP meeting. With the tremendous dedication of my MOA (essential for its success) my office is running smoother, the volume is less overwhelming and patients are being seen in a more timely manner. The biggest pearl from the sessions was the freezing and unblocking of appointments the week returning from holiday – what a difference!"

Dr. Wendy Woodfield, Vancouver
Currently participating in the
Advanced Access module.

In recent years many BC general practitioners have expressed concern that they are finding it increasingly difficult to see their patients in a timely manner. In some practices a backlog of appointments has resulted in some patients having to wait as long as two weeks to see their physician. Physician concerns regarding whether the appointment delays are affecting the quality of patient care can be further compounded by the strain on the patient-physician relationship that can result from patient dissatisfaction with how long it takes to see their doctor.

There is a way to improve this situation. Advanced Access (also known as "Same Day" access) is a scheduling system that has been proven to reduce patient wait times for appointments. Excellent results have been demonstrated in GP offices in Canada (including BC), the U.S., and Europe, and among physicians who work in the fee-for-service system and those under alternative payment arrangements.

The key to advanced access scheduling is to 'do all of today's work today'. This scheduling system does not distinguish between urgent and routine appointments. Instead, appointment times are made available each day and patients calling to schedule a physician visit are offered an appointment the same day regardless of the reason for the visit.

The benefits of doing "today's work today" through using an advanced access scheduling system identified by the physicians using the system are:

- Satisfied, more confident patients;
- More time to manage chronic illnesses;
- Reduced stress due to trying to cope with appointment backlog;
- Better use of time and resources;
- Increased quality of professional life;
- Increased practice revenue through (e.g., BC physicians have reported an average increase of 20-25% in practice revenues after implementing advanced access scheduling); and
- Order and a sense of control are restored to the practice.

Earlier this year, the General Practice Services Committee (a joint committee of the BC Ministry of Health, BC Medical Association and the Society of General Practitioners of B.C) launched the Practice Support Program across the province. The Practice Support Program is assisting GPs interested in changing various aspects of their clinical practice for improved quality of patient care and professional satisfaction.

Assistance with implementing an advanced access scheduling system is available to BC GPs and their MOA's through the Practice Support Program. Training is delivered throughout the province by Health Authority Regional Practice Support Teams that are made up of GP and MOA peer champions and family practice resource personnel.

GPs and their staff can learn how to reduce their backlog of appointments and implement this innovative way of reducing patient appointment wait time by participating in regional training sessions or through self-guided learning using the step-by-step practice guide available at the following website: http://www.practicesupport.bc.ca/. At this website, also view the video, "Taming the Queue" featuring BC GPs who have implemented advanced access scheduling in their busy practices.

Implementing an advanced access scheduling system in your office is fully doable within a few months of concerted effort. For more information on the Practice Support Program learning materials and training on how to implement advance access scheduling, contact:

Liza Kallstrom
604-638-2854
lkallstrom@bcma.bc.ca

Maria dela Cruz
604-638-2873
mdelacruz@bcma.bc.ca

Rosemary Gray
250-952-3384
rosemary.gray@gov.bc.ca

BC Guide for Physicians in Determining Fitness to Drive a Motor Vehicle

The Office of the Superintendent of Motor Vehicles (OSMV), in partnership with the British Columbia Medical Association (BCMA) have revised the *BC Guide for Physicians in Determining Fitness to Drive a Motor Vehicle* (the Guide). The revisions reflect changes to the case law and provide the best evidence available regarding medical conditions and fitness to drive.

Chapters may be viewed at Drivesafe.com on the public site of the BCMA Web site and at the Society of General Practitioners of BC Web site.

Multiple Diagnostic/Therapeutic Procedures Performed at the Same Sitting

When multiple diagnostic/therapeutic procedures are performed at the same sitting, the procedure having the largest fee is billed at 100% of the listed fee. The remaining procedure(s) are billed at 50% of the listed fee(s), unless otherwise indicated in the Payment Schedule.

Procedures listed as "extra" will be paid at 100% for the first "extra", and 50% for any additional procedures listed as "extra", unless otherwise indicated in the Payment Schedule.

Two Diagnostic/Therapeutic Procedures Performed By Two Physicians at the Same Sitting

When two diagnostic/therapeutic procedures are performed by two physicians at the same sitting, and both procedures are within the competence of either physician, the total fee claimed should be no greater than that which would be payable if both procedures were performed by one physician.

Note: See Preamble B.11 of the MSC Payment Schedule for more information on billing multiple services, it is listed under Diagnostic and Selected Therapeutic Procedures.

http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html

Refusal Codes "AM" and "AQ"

If your claim has been refused with explanatory code "AM" or "AQ" it is due to an error in the patient initials or surname. There is an easy way to check the correct spelling of your patient's name using our 24-hour coverage information line. We encourage you to use this convenient service to verify your patients' names and coverage status.

Telephone:
In Victoria (250)383-1226
In Vancouver (604)669-6667
All other areas of BC (toll free) 1-800-742-6165

Press 1 then press 4

Designated Statutory Holidays	2008		Close-Off Dates	
Jan 01	Tue	New Year's Day	Jan 04	July 04
Mar 21	Fri	Good Friday	Jan 22	July 22
Mar 24	Mon	Easter Monday	Feb 06	Aug 06
May 19	Mon	Victoria Day	Feb 20	Aug 20
Jul 01	Tue	Canada Day	Mar 05	Sep 04
Aug 04	Mon	BC Day	Mar 18	Sep 19
Sep 01	Mon	Labour Day	Apr 04	Oct 03
Oct 13	Mon	Thanksgiving Day	Apr 21	Oct 22
Nov 11	Tue	Remembrance Day	May 06	Nov 04
Dec 25	Thur	Christmas Day	May 21	Nov 19
Dec 26	Fri	Boxing Day	Jun 04	Dec 04
			Jun 19	Dec 18

Billing Reminder - Continuing Care from Previous Patient (CCFPP)

When more than one patient is seen on the same special call-out, the following rules apply:

- When a physician is called out to attend more than one patient, the physician may bill non-operative continuing care surcharges (fee items 01205, 01206, 01207) for each half-hour of care provided as long as all the criteria for those fees are met (one service per half hour only).
- Non-operative continuing care surcharges are also applicable without the 30-minute time lapse, and with timing continuing, to immediately subsequent patients seen on the same call-out under the following circumstances:
  i) as an emergency;

CCFPP must be noted *on the first line of your note record* for all claims where care is continuing from a previous patient.

If your note record does not indicate "CCFPP" on the first line for these cases, the 30-minute refractory period will be deducted from your payment.

Note that timing is based on the total time spent providing continuous care, not the number of patients seen (e.g., if three patients are seen in one half-hour period, the applicable non-operative continuing care surcharge may be charged only for the last patient seen in that half-hour period).

Example:

Patient	Time Called	Time Start	Time End	Bill
Patient 1	1840	1900	1930	01200 00100
Patient 2		1930	1942	00100
Patient 3		1942	2002	00100 01205 X 1
Patient 4		2002	2100	00100 01205 X 2 (CCFPP)
Total Time		**1900**	**2100**	

Note: Timing Begins after first 30 minutes so 3 X 01205 is billable in total.

Ontario Health – Health Care Security Enhancements

The Ministry of Health and Long-Term Care in Ontario recognizes the importance of having a secure Health Card and is introducing changes to enhance the security of its current card. These additional security enhancements will make the Health Card more tamperproof and counterfeit resistant. In order to further protect personal health information, address information has been removed from the back of the Health Card.

Ontarians will not receive an enhanced Health Card until their current card expires, or a replacement card is required. Both the red and white and the current photo health card remain acceptable as proof of entitlement to medically necessary insured health services providing they are valid and belong to the person presenting the card.

The additional security features include:

- A new security background
- Secondary photo and signature
- Tactile features (Health Number, Version Code, and Ontario trillium logo)
- A 2D bar code

Physician Referrals for Dental Services

Reminder to Physicians and Staff

It has become apparent from letters received at the Ministry of Health that some patients are not aware that they may have to pay for dental procedures performed in private dental offices following a physician's referral.

For example, if a family physician refers a patient to an oral surgeon for a consultation regarding an intra-oral lesion and the oral surgeon performs a biopsy in their dental office the patient may be billed for the service. The patient would be charged because surgical dental procedures are only covered by the MSP when performed in a hospital. If the patient has private dental insurance they may have coverage for the procedure; patients without private dental insurance would be responsible for payment.

Please take the time to inform patients being referred to a dentist that there may be charges for services that are not covered by MSP.

Personal Health Numbers for Newborns

It has come to our attention that some hospitals are providing personal health numbers (PHN) for newborns. It is important to note that although the baby has been provided with a PHN by the hospital the family must still register the baby with the MSP.

- To do this they need to fill out the forms that are provided in their baby enrolment package.
- For questions they can contact MSP at 604 683-7151.

Note: When services for the baby are billed using the PHN provided by the hospital, it has been suggested that "baby boy" or "baby girl" should be used for the first initial of the child and the surname should be the same as how baby will be registered at vital statistics.

If the hospital does not provide a PHN and the newborn has not been registered with the MSP, services can be billed under the mother's PHN using dependent number 66. Please note that the mother must have valid MSP coverage.

The maximum period during which MSP will cover an unregistered baby under the mother's PHN is the month of birth plus the following two months.

Audit Reports

Dr. A. – General Practice

An audit of a general practitioner found an inappropriate pattern of billing complete physical examinations and counselling, which were not supported by the medical record and where a visit fee item of lesser value would have been more appropriate.

As a result of a mediated settlement, the physician agreed to repay the Commission $54,000, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule.

Dr. B. – General Practice

A family physician came to the attention of the MSC because of high average costs and services per patient, which could not be explained by case-mix adjustment for patient morbidity. Costs appeared to result from a high volume and frequency of complete physical examinations, counselling and house calls. A peer medical inspector examined a representative sample of charts and noted missing or inadequate medical records, inappropriate use of 00103 home visits and 1200-series out-of-office premiums for provision of chronic continuing care, complete physical examinations and counselling that were not substantiated by the records, and injections claimed as office visits. It was also noted that some records were not contemporaneous with the date of service but had been prepared retrospectively. The inspector also noted that the physician was otherwise providing high quality care for a large number of complex patients in an under serviced area.

As a result of a mediated settlement, the physician agreed to repay the MSC $40,000 inclusive of costs and interest, and abide by a pattern of practice order in which adequate records would be promptly prepared at the time of service, home visits and call-out premiums would not be submitted for chronic continuing care in patients' homes, and would comply with the MSC Payment Schedule in respect to complete physical examinations, counselling and injections.

Dr. C - Paediatrician

A paediatrician with a mixed specialist and general practice came to the attention of the MSC because of high costs per patient, which could not be explained by case-mix adjustment. An onsite audit was ordered by the MSC and carried out by paediatric and general practice peer medical inspectors. The audit was unable to determine the medical necessity for a number of claims of 101-series complete examinations because of missing or inadequate records. There were also instances where the practitioner failed to deliver consultation reports to referring physicians.

As a result of a negotiated settlement, the physician agrees to repay the MSC $20,000, inclusive of audit costs and interest and abide by a pattern of practice order in which adequate records would be maintained, consultation reports promptly delivered to referring physicians, and complete examinations claimed in compliance with the MSC Payment Schedule.

Dr. D. – General Practice

A physician specializing in varicose vein surgery came to the attention of the MSC because of a high cost per patient. An onsite audit was performed by a peer medical inspector who found a few errors pertaining to missing records, incorrect billing of 'complicated' sclerotherapy, and inappropriate billing of 0100 office visits incorrect in association with unreferred patients and uninsured surgery.

As a result of a mediated settlement, the physician agreed to reimburse the MSC $32,500, inclusive of costs and interest, and abide by a pattern of practice order in which:

- adequate records will be maintained;
- MSP will not be billed for consultations or visits prior to uninsured services;
- treatment of surgical complications following cosmetic surgery may be billed only when the complication is acute and unexpected and not considered part of routine post-operative care;
- visits may be billed on the day of surgery, only when the visit and surgery are for unrelated conditions; and
- the most specific ICD9 code will be used that best describe the patient's condition.

Dr. E - Emergency Medicine

A general practitioner engaged in full time emergency medicine practice was audited by the MSC because of an unusually high cost per patient, stemming directly from a disproportionately higher rate of Level II and III Emergency Care billings. A medical peer inspected a representative sample of the physician's records and found that some visits were payable as lesser levels of care.

As the result of a negotiated settlement, the physician agreed to repay the MSC $13,000, inclusive of interest, and comply with a pattern of practice order in which the physician would comply with the Emergency Medicine Preamble in respect to criteria for levels of complexity of care and maintain adequate medical records.

Dr. F - General Practice

Dr. F, a general practitioner who practises as an emergency room physician, was investigated by the Billing Integrity Program for an unusually high percentage of Level III emergency care claims in relation to claims for Level I & II emergency care. Dr. F was referred to the Audit Inspection Committee (AIC) for an on-site inspection and audit. The audit found that Dr. F had billed Level III emergency care inappropriately for a number of claims when Level I & II should have been billed. Dr. F was required to pay back more than $40,000 (including interest and partial audit costs) to the MSC.

When should you call WorkSafe BC?

Questions concerning the general submission or adjudication of claims should be directed to Health Insurance BC (HIBC). However, questions you may have concerning WorkSafe BC not accepting a claim or about billings that have been rejected with a WorkSafe BC explanatory code should be directed to them.

Special Authority Coverage of Insulin Glargine (Lantus®)

Effective August 1, 2007, the long-acting insulin, insulin glargine, became available for PharmaCare coverage through the Special Authority (SA) process for:

Patient is over 17 years of age and has been diagnosed with Type 1 or Type 2 diabetes requiring insulin and is currently taking insulin NPH and/or pre-mix insulin daily at optimal dosing: AND –

1. Has experienced unexplained nocturnal hypoglycemia at least once a month despite optimal management. OR –
2. Has documented severe or continuing systemic or local allergic reaction to existing insulin. (See Special Notes below)

Note: For item #2 above, documentation of previous trials (i.e., specific insulins used and patient's response) is required.

A specialty exemption for insulin glargine for endocrinologists has been created. This means that insulin glargine prescribed on or after August 1, 2007, is covered for all eligible patients of BC endocrinologists. Additionally, if insulin glargine is initially prescribed by an endocrinologist on or after August 1, 2007, an indefinite SA approval will be created for the patient (this is known as an Assumed SA). Therefore, when an endocrinologist is the initial prescriber, general practitioners and other prescribers do not need to submit an SA request to maintain the patient's insulin glargine coverage.

Coverage of insulin glargine is subject to the usual rules of a patient's BC PharmaCare plan, including any deductible requirement. Retroactive coverage cannot be provided for prescriptions filled before SA approval is in place.

Reminder: As per the manufacturer's product monograph, insulin glargine must not be diluted or mixed with any other insulins or solution.

Biologics for Ankylosing Spondylitis and Psoriatic Arthritis

Now available as Limited Coverage Drugs through the PharmaCare Special Authority Program

Ankylosing Spondylitis

Pharmaceutical Services Division is pleased to announce that, effective March 14, 2008, adalimumab (Humira®), etanercept (Enbrel®) and infliximab (Remicade®) became eligible for PharmaCare coverage through our Special Authority Program for the treatment of ankylosing spondylitis subject to established criteria.

Coverage is available for the following dosing frequencies:

- Adalimumab—40 mg every 2 weeks
- Etanercept—25 mg twice weekly or 50 mg weekly
- Infliximab—5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter. Renewal coverage—3 to 5 mg/kg every 8 weeks.

All requests for ankylosing spondylitis drugs must be submitted by a rheumatologist.

All criteria and forms are available in the Special Authority section of our website at www.health.gov.bc.ca/pharme/. Please note that Special Authority coverage cannot be provided retroactively and that actual coverage is subject to the patient's usual PharmaCare plan rules, including any deductible requirement.

Psoriatic Arthritis

Effective March 14, 2008, infliximab (Remicade®) became eligible for coverage as a Limited Coverage Drug through our Special Authority Program for the treatment of psoriatic arthritis subject to established criteria.

Coverage is available for the following dosing frequencies:

- Initial coverage—5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter
- Renewal Coverage—5 to 5 mg/kg every 8 weeks.

Please note that adalimumab (Humira®) and etanercept (Enbrel®) for psoriatic arthritis are already covered for patients who meet the PharmaCare Special Authority criteria.
All requests for both psoriatic arthritis drugs must be submitted by a rheumatologist.

All criteria and forms are available in the Special Authority section of our website at: www.health.gov.bc.ca/pharme/.

Please note that Special Authority coverage cannot be provided retroactively and that actual coverage is subject to the patient's usual PharmaCare plan rules, including any deductible requirement.
Modification of Special Authority Forms for

Rheumatoid Arthritis

We have also modified the Special Authority forms for rheumatoid arthritis. Only two forms are now required:

- HTLH 5345 Rheumatoid Arthritis–Initial Coverage or Switching Coverage for 1 year, and
- HLTH 5354 Rheumatoid Arthritis–Renewal Coverage for 1 year or indefinite, depending on dosing.

All criteria and forms are available in the Special Authority section of our website at www.health.gov.bc.ca/pharme/.

New and Updated Explanatory Codes

The following are new explanatory codes

AU A claim for this service has been paid on the mother's PHN#, under dependant 66.

LS Age related annual complex care block fee items must be provided on the same date of service as complex care planning fee item 14053.

LT This service is not payable on inpatients or patients who reside in a care facility.

LV This service is limited to once per calendar year per patient and has been paid to another practitioner.

LW This service is only payable if the patient is seen and a visit billed on the same date. Please resubmit for both services, if applicable.

NS You have reached or exceeded the practitioner calendar year limit for this service.

RN Dental/oral surgery with extractions-the higher gross fee item(s) are paid at 100% and extractions in the same quadrant paid as "each additional tooth".

RO Multiple dental/oral surgeries are paid as the larger fee at 100%; the lesser fee at 50% unless otherwise stated in the MSP Dental schedule.

RQ This fee item is payable once per jaw.

RS A claim for this service has been paid within the previous 12 months.

RT A claim for this service has been paid within the previous 12 months to another practitioner.

RW This fee item is not applicable unless continuous time is spent with the patient.

RX Critical care fees are not applicable when the service starts after 2200 hours.

RY The maximum rate paid for these multiple laparoscopic operations is the rate payable for fee item 04229. This service exceeds the maximum.

The wording has been changed for:

T1 Extractions in conjunction with osteotomies/ fractures-bill extractions as "each additional tooth per quadrant" regardless of the number of quadrants involved.

Changes have been made to:

AY Provincial/insurer or institutional code missing or invalid or fee item not valid for insurer.

LH [illegible] applicable to general, regional and monitored anesthesia.

WorkSafe BC Explanatory Codes

New WorkSafeBC Explanatory Code

O3 (alpha O) WorkSafeBC refused payment Expedited consult cancelled less than 24-hour notice or no-show occurred. If clarification req'd contact WSBC Payment Services Department.

WCB code G3 has been changed to the following: WorkSafe BC has refused your claim pending submission of required form. If clarification required please contact WorkSafe BC Payment Services.

List of Inserts

- Update to the Payment Schedule
- Revision of Complex Care Fees
- Community-Based Mental Health Initiative

The Billing Integrity Program

Everything you want to know but were afraid to ask

In order to understand why a system of audit and inspections has been established in British Columbia, it is necessary to review the history of medical care insurance in the province. When medical care insurance was established in BC (initially on an entirely private insurer basis), the British Columbia Medical Association (BCMA) was very much involved in setting up the "honour system" of billings that is the mainstay of the current system. There were different models that could have been adopted. A deliberate decision was made to have doctors submit claims and, other than undertaking a few basic validations, the claims were paid as quickly as possible. This was particularly the case when publicly administered medical care insurance was initially established in BC in 1965 for those citizens who were not covered by private insurance and subsequently in 1968 when medicare became universally available in BC. British Columbia was the first jurisdiction in North America where the medical profession and government jointly entered into an agreement regarding publicly funded medical care insurance.

It was accepted by both parties that, apart from a small minority, doctors were honest and it would be unfair to penalize the honest majority in order to detect the small minority that might take advantage of such an honour system. Billings are reviewed after the payment has been made in order to detect unusual billing patterns. The alternative to the system adopted in BC is used by many private insurers where billings either require pre-approval or undergo careful scrutiny before they are paid. Such alternative systems have significantly larger administrative costs and delay the payment to the service provider considerably.

As part of its agreement with government, the BCMA established the Patterns of Practice Committee (POPC) that reviewed doctors' billing patterns and made recommendations to the MSC regarding aberrant billing patterns. Computerized practitioner billing profiles ("practitioner profiles") were developed so the process could be done effectively and efficiently. As time passed, the practitioner profiles became progressively more sophisticated and lawyers began to be involved in the process representing the doctors under review. As the process became more complex from a legal perspective, the legislation under which MSC operates had to be improved to reflect the increasingly formalized legal environment. The BCMA POPC did not have the appropriate authority or the resources to operate in such a legal environment and in the early to mid 1990s decided to step back from the process to a great extent. Consequently, the Billing Integrity Program (BIP) was formed to deal with the complexities of a post-billing audit system.

Each year, MSC produces a very large and detailed computerized analysis of each practitioner's billings known as the "practitioner profile". Because this computer printout is so large and complex, the BCMA produces a much smaller version known as the "mini profile" that has graphical representation and simplified statistical parameters. The "mini profiles" are distributed by the BCMA to all physicians billing MSP so that doctors can see if their billings are within the normal statistical boundaries of their peer group. This provides doctors with an opportunity to identify potential billing issues that may require corrective action.

The role of the BIP is to detect, deter and recover inappropriate fee-for-service billings on behalf of the MSC. The BIP uses a variety of methods to identify and investigate high risk practices, including service verification surveys of beneficiaries, statistical analysis of claims data to identify unusual patterns of practice and receipt of complaints from the public, profession and third-party insurers. Because the burden of illness or co-morbidity within practices can vary widely, there is a section within the practitioner profiles where practice costs are case-mix adjusted, utilizing a methodology developed by Johns Hopkins University, to account for the relative burden of illness within a given practice. Where feasible, BIP staff will ask for a written explanation from a physician regarding an unusual billing pattern but, if doubt remains, the case is referred to the MSC's Audit and Inspection Committee (AIC), which has the delegated authority to conduct an on-site audit, under s.36 of the *Medicare Protection Act and Regulations (Act)*. Although the AIC is responsible solely for audits and inspections of physicians' practices, there is a similar process that applies to all other health care practitioners who submit claims to MSP.

If the AIC orders an on-site audit, then an audit team is assembled, composed of forensic accounting and administrative staff from the BIP plus a peer medical inspector jointly nominated by the BCMA and College of Physicians and Surgeons of BC. The team is onsite in the doctor's office for approximately one – three days and the medical inspector reviews a statistically valid sample of medical charts representative of the previous five years of practice. This typically includes the detailed review of the physician's clinical records of 40-50 discrete patients that usually represent about a thousand individual claims over the five-year period that is the usual span of an audit. The medical inspector's role is to assess the claims, based on seven standard criteria:

- was the service medically necessary (as required by the *Act*) and is there evidence that the service was actually performed?
- is there an adequate medical record documenting the service billed?
- is the service an insured benefit under the *Act*?
- was the correct fee item used?
- does the practitioner number submitted on the claim correctly identify the person who performed the service?
- are there quality of care concerns? and
- is the frequency of service justified?

The sampled claims are reviewed in detail and are either accepted, adjusted to the value of the correct fee item or rejected. The findings are then summarized in a detailed audit report that is submitted to the AIC. The percentage of errors in the sampled claims (i.e., those MSP claims that are determined to have been paid incorrectly for whatever reason) is then extrapolated for all claims paid for the five-year audit period. This statistical process has been independently reviewed and verified as valid. Although a five-year audit period may seem excessive to some, it has been found that by the time the audit issues have been identified and investigated in the honour system by which billings are submitted, considerable time may have passed and the recovery of the incorrectly disbursed public funds is warranted. Before the audit team completes the report, the physician is provided with the opportunity to review the report and clarify any aspect of the report that may not be correct. Following this, the report is finalized and submitted to the AIC.

Where there are no substantive findings, the AIC will close the file and advise the physician. However, when the pattern of practice is not justifiable, the AIC will recommend that the MSC seek financial recovery and/or order that the physician abide by an appropriate pattern of practice or billing. The physician has an option to use an alternate dispute resolution (ADR) process in which the physician and BIP representatives attempt to negotiate a settlement for consideration by the Chair of MSC. In the event that the matter is not resolved through the ADR process, the physician has the right to a hearing. The hearing panel is usually comprised of a government appointed chair who is a lawyer, three practising peers and a lay member of the public. In this quasi-judicial setting, the panel will hear evidence under oath and the physician is entitled to be represented by legal counsel. After hearing the evidence presented, the panel will render a decision which may include a determination that the physician owes nothing or any one or more of the following:

- recovery of payments based on the quantified billing errors extrapolated over the entire audit period, with costs and interest;
- issue a pattern of practice order requiring the physician on future compliance with the Payment Schedule;
- modify the physician's billing rights, either on an opted-out basis (where the physician must bill the patient directly according to the Payment Schedule and the patient is reimbursed by MSP) or on a de-enrolled basis (where the physician may bill whatever the market will bear but the patient is not entitled to any re-imbursement by MSP) – in both these instances the physician must inform the patient of all the details before the service is rendered.

In all cases that proceed to a hearing, it is the policy of the MSC to publish the physician's name and a summary of the case in the MSP Physicians' Newsletter. As well, the College is also notified.

Notwithstanding the formal hearing process described above, most cases are settled through the ADR process. In those rare cases of repeated non-compliance with practice orders or fraud, the MSC may order permanent de-enrolment of billing privileges, subject to the right of the physician to a hearing, and/or refer the case for consideration of criminal charges by law enforcement authorities.

Revised - Electronic Storage of Diagnostic Facility Requisitions

In accordance with Sections 5 (1) (a), (c), (e), (j) and (l) and 27, of the *Medicare Protection Act*, the following outlines the circumstances under which claims for diagnostic services associated with requisitions which are stored electronically will be payable by the MSP.

1. The electronically stored requisitions must be retained and available for inspection for a period of six (6) years from the original date of the requisition. The diagnostic facility may purge their electronically stored requisitions after the six year period has elapsed.

2. Electronically stored requisitions cannot be destroyed if the practitioner and/or facility are being audited or have received notice of a pending audit.

3. Any physician and/or diagnostic facility using electronic storage must ensure that the system complies with the Canadian General Standards Board requirements for Microfilm and Electronic Images as Documentary Evidence, which are updated from time to time. Additional technical requirements apply and are attached.

4. The implementation date of the revised electronic storage of diagnostic facility requisitions is effective immediately.

The revised policy is online at: http://www.hlth.gov.bc.ca/msp/infoprac/diag.html

Technical Requirements

a) Electronic images of requisitions must be readily retrievable and easily printed in the presence of an auditor or inspector, by date and name or Personal Health Number.
b) In the event of a disaster, a backup copy of the electronic images must be available and securely maintained off-site.
c) The system must be secure and tamper proof. The image must be stored using WORM (write once, read many) technology.
d) File Format – single page Tagged Image File Format (TIFF). Files will need to be monitored to ensure they remain accessible.
e) For electronic images to be considered as documentary evidence the following are required:
   i) documentation of business rules
   ii) documentation of scanning policy and procedures, including access restrictions and security of the original scanned documents
   iii) documentation of built-in audit and quality assurance processes
   iv) records retention and disposition schedules must be developed, approved and implemented
f) Compression: Image compression must be lossless
g) Dots Per Inch (DPI): Minimum standard for routine black and white documents, 400 DPI, coloured documents may require higher DPI for clarity and sharpness.
h) Indexing: Diagnostic Facilities need to establish acceptable metadata requirements for searching and speeding information retrieval times, with established business rules and controlled vocabulary.
i) Diagnostic Facilities need to develop and document proper disposition procedures for electronic media.

Billing Fee Items

00510 – Pediatric Consultation
00118 – Attendance at Caesarean Section

It was recently confirmed with the British Columbia Medical Association (BCMA) that it is inappropriate for Pediatricians to bill a Pediatric consultation in combination with fee item 00118.

It states in the MSC Payment Schedule Preamble that in order for a consultation to be paid there must be a formal request for a consultation by the treating physician.

The following statement is listed in the Payment Schedule under Preamble B. 3. "A consultation must not be claimed unless it was specifically requested by the attending physician/practitioner/midwife". Therefore, if a consultation was not formally requested by the treating physician, it should not be billed. Although not specifically restricted, fee item 00118 is a general practice (GP) fee item originally intended to be billed by GP's.

BRITISH COLUMBIA
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Update to the Medical Services Commission
Payment Schedule

Preamble

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective August 1, 2007:

New Fee Items:

The following new fee items are hereby added to Preamble A. 7.:

Miscellaneous (...99) Fee Items

33199 Cardiology
33299 Endocrinology and Metabolism
33399 Gastroenterology
33499 Geriatric Medicine
33599 Hematology and Oncology
33699 Infectious Diseases
33899 Nephrology

Amendment:

The following fee item description is hereby amended as indicated:

00399 General Internal Medicine

Out-of-Office Hours Premiums

In accordance with Section 26(3) of the *Medicare Protection Act*, the following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective April 1, 2008:

P01215	Evening (service rendered between 1800 hrs. and 2300 hrs.) - per half hour or major part thereof	$39.95
P01216	Night (service rendered between 2300 hrs. and 0800 hrs.) - per half hour or major part thereof	$60.14
P01217	Saturday, Sunday or Statutory Holiday (call placed between 0800 hrs. and 1800 hrs.) - per half hour or major part thereof	$43.98

Notes:

i) State time called and time service rendered.

ii) Where timing is continuous submit an account for each patient, indicating "CCFPP" (continuing care from previous patient).

iii) *Not applicable to full or part-time emergency physicians or to on site practitioners providing coverage in drop-in emergency clinics or hospital emergency rooms.*

iv) *When emergency services commence prior to 1800 hours (weekday) and extend beyond 1800 hours, anesthetic surcharges are applicable to the time after 1800 hours. Timing begins at 1800 hours and surcharge payments are based on one half hour of care or major portion thereof. Therefore, the 01215 surcharge in these cases is payable after 15 minutes of continuous care (i.e.: 1815 hours)*

v) *When emergency anesthetic services commence prior to 0800 hours and continue after 0800 hours, anesthetic surcharges are only applicable to the time prior to 0800 hours.*

vi) *Anesthetic surcharges are applicable to services associated with elective surgery which, because of intervening emergency surgery, extends into or commences within the designated times.*

General Services

The following modifications have been made to the Payment Schedule, effective October 19, 2007:

Amendment

The following fee is hereby amended by modifying the indicated note:

T00039 Methadone treatment only $21.04

Notes:

ii) 00039 is the only fee payable for any visit or medically necessary service associated with methadone maintenance therapy. This includes but is not limited to the following:

(b) At least two visits per month with the patient after induction/stabilization on methadone is complete. Exceptions to this criterion are where the patient resides/works in an isolated locale which is a significant distance from the prescribing physician.

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective April 1, 2008:

Amendment:

The cancellation date of the following provisional items have been extended. This Minute will expire on September 30, 2009 or when replaced by a subsequent Minute, whichever occurs first:

P10010 DTaP-P (Diphtheria, Tetanus, Pertussis, Polio) $3.00

P10011 DTaP-P-Hib (Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b) $3.00

Note: *Not payable with P10010 or P10018 on the same day, same patient.*

P10012 Td (Tetanus, Diphtheria) $3.00

P10013 TdP (Tetanus, Diphtheria, Polio) $3.00

Note: Not payable with P10012 or P10019 on the same day, same patient.

P10014	TdaP (Tetanus, Diphtheria, Pertussis) ***Note:*** *Not payable with P10013 on the same day, same patient.*	$3.00
P10015	Flu (Influenza)	$3.00
P10016	HA (Hepatitis A)	$3.00
P10017	HB (Hepatitis B)	$3.00
P10018	HiB (Haemophilus influenza type b) ***Note:*** *Not payable with P10011 on the same day, same patient.*	$3.00
P10019	IPV (Polio Vaccine - Inactivated) ***Note:*** *Not payable with P10010, P10011 or P10013 on the same day, same patient.*	$3.00
P10020	MEN-C-C (Meningococcal-Conjugate-C)	$3.00
P10021	MEN-P-ACYW135 (Meningococcal-Polysaccharide-ACYW135)	$3.00
P10022	MMR (Measles, Mumps, Rubella)	$3.00
P10023	PNEU-C-7 (Pneumococcal Conjugate C-7)	$3.00
P10024	PNEU-P-23 (Pneumococcal-Polysaccharide-23)	$3.00
P10025	RAB (Rabies)	$3.00
P10026	VAR (Varicella)	$3.00

Notes:

i) For immunizations of patients age 19 or older, use fee item B00010, B00034.

ii) Not payable for immunizations required for travel, employment and emigration.

iii) Payable per injection.

iv) Payable in full with an office visit to a maximum of 4 injections per patient per day.

v) Not payable on the same day with B00010, B00034.

Diagnostic Services

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective as indicated:

Deleted Fee Items

The following fee items are hereby deleted, effective November 30, 2007:

S00960	Ear oximetry to measure arterial O_2 saturation – professional fee
S00961	Ear oximetry to measure arterial O_2 saturation – technical fee

New Fee Items

The following items have been approved on a provisional basis, effective December 1, 2007, and will be monitored for 18 months. This Minute will expire on May 31, 2009, or when replaced by a subsequent Minute, whichever occurs first:

PS11960	Oximetry at rest, with or without Oxygen – professional fee	4.62
PS11961	Oximetry at rest, with or without Oxygen – technical fee	5.00
PS11962	Oximetry at rest and exercise, with or without Oxygen – professional fee	10.00
PS11963	Oximetry at rest and exercise, with or without Oxygen – technical fee	15.64

Amendments

The payment rates of the following fee items are hereby amended as indicated, effective December 1, 2007:

	Exercise in a steady state at two or more work loads with measurements of ventilation, 0_2 and $C0_2$ exchange, and electrocardiographic monitoring:	
S00954	-professional fee	90.18
S00955	-technical fee	57.93
	Exercise in a steady state at two or more work loads with measurements of ventilation, 0_2 and $C0_2$ exchange, electrocardiographic monitoring, arterial blood gases, measurement of Aa gradients and physiological dead space:	
S00956	-professional fee	107.36
S00957	-technical fee	68.97

Emergency Medicine

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective April 1, 2006:

Amendment

The payment rates for the following Emergency Medicine items are hereby amended as indicated.

These modifications will be monitored for a period of one year, effective September 1, 2007 to August 31, 2008. After this time, they will be adjusted retroactively and prospectively to ensure that the actual monetary impact equals the expected impact.

01810	Emergency medicine consultation	127.77
	Level I emergency care:	
01811	- day	29.52
01821	- evening	37.11
01831	- night	56.79
01841	- Saturday, Sunday or Statutory Holiday	37.11
	Level II emergency care:	
01812	- day	50.60
01822	- evening	63.22
01832	- night	94.96
01842	- Saturday, Sunday or Statutory Holiday	63.22

	Level III emergency care:	
01813	- day	67.27
01823	- evening	83.65
01833	- night	133.95
01843	- Saturday, Sunday or Statutory Holiday	83.65
	Fractures:	
01850	Clavicle – adult	103.56
01851	Fibula – shaft or malleolus – not requiring reduction	89.59
	Dislocations:	
01860	Temporo-mandibular joint, dislocation – closed reduction	67.63
01861	Patella – closed reduction	64.78
01862	Toe – closed reduction	48.58

General Practice

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective September 1, 2007:

New Fee Items:

The following items have been approved on a provisional basis, effective as indicated. This Minute will expire on February 28, 2009, or when replaced by a subsequent Minute, whichever occurs first:

P13228 Full Service Family Medicine (hospital) visit 26.51

Notes:

i) Payable once per calendar week per patient up to the first four weeks. Thereafter, payable once per two weeks up to a maximum of 90 days. For visits over 90 days please submit note record.

ii) Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

iii) Payable to practitioners currently in general practice in BC as a full service family physician.

iv) Payable for patients in acute, sub-acute care or palliative care.

v) Not payable with 14015 or any other visit fee including P13229, 00108, 13108, 00109, 13114, 00114, 00115, 00113, 00105, 00123, 00127, 13127, 12200, 13200, 16200, 17200, 18200, 12201, 13201, 16201, 17201, 18201, 12148, 13148, 00128, 13128, 13015, 12220, 13220, 16220, 17220, 18220, 00121, 00122, 12110, 00110, 16110, 17110, 18110, 00116, 00112, 00111.

vi) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the patient as a requirement of their employment or contract with the facility or physicians working under salary, service contract or sessional arrangements.

vii) A written record of the visit must appear in either patient's hospital or office chart.

viii) This fee is intended for physicians with courtesy or associate hospital privileges.

ix) If a hospitalist is providing GP care to the patient, the full service family physician may bill P13228 or P13229 (if first visit of day).

P13229 Full Service Family Medicine (hospital) visit – 1st visit of the day 53.02

Notes:

i) Payable only for first in-hospital patient seen on any calendar day.

ii) Payable once per calendar week per patient up to the first four weeks. Thereafter, payable once per two weeks up to a maximum of 90 days. For visits over 90 days please submit note record.

iii) Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

iv) Payable to practitioners currently in general practice in BC as a full service family physician who are responsible for providing the patient's longitudinal general practice care.
v) Payable for patients in acute, sub-acute care or palliative care.
vi) Not payable with 14015 or any other visit fee including P13228, 00108, 13108, 00109, 13114, 00114, 00115, 00113, 00105, 00123, 00127, 13127, 12200, 13200, 16200, 17200, 18200, 12201, 13201, 16201, 17201, 18201, 12148, 13148, 00128, 13128, 13015, 12220, 13220, 16220, 17220, 18220, 00121, 00122, 12110, 00110, 16110, 17110, 18110, 00116, 00112, 00111.
vii) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the patient as a requirement of their employment or contract with the facility or physicians working under salary, service contract or sessional arrangements.
viii) A written record of the visit must appear in either patient's hospital or office charts.
ix) This fee is intended for physicians with courtesy or associate hospital privileges.
x) If a hospitalist is providing GP care to the patient, the full service family physician may bill P13228 or P13229 (if first visit of day).

Amendment

The following fee item is hereby amended by increasing the payment rate and modifying the note as indicated. The implementation date for this modification will be December 1, 2007, or earlier. Retroactive adjustments will be made for services provided before the implementation date.

T14545 Medical abortion 128.14
Note: *Includes all associated services rendered on the same day as the abortion including the consultation whenever rendered, required components of Rh factor, associated services including counselling rendered on the day of the procedure, and any medically necessary clinical imaging.*

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective immediately:

Amendment

Note iii) following the indicated fee item is hereby amended as follows:

P13228 Full Service Family Medicine (hospital) visit.....26.51
iii) Payable to practitioners currently in general practice in BC as a full service family physician who are responsible for providing the patient's longitudinal general practice care.

Amendment

The cancellation dates of the following provisional items have been extended. This Minute will expire on January 31, 2009 or when replaced by a subsequent Minute, whichever occurs first:

P13020 Telehealth General Practitioner Assistant – Physical Assessment as requested by receiving specialist: - for each 15 minutes or major portion thereof.....27.90
Notes:
i) Applicable only if general practitioner is required at the referring end to assist with essential physical assessment, without which the specialist service would be ineffective.
ii) Applies only to period spent during consultation with specialist.

Amendment

The following fee items are hereby amended by modifying the indicated notes:

T12148 Sub-acute hospital visit.....31.31

Notes:

i) Payable only when provided to patients who have had an acute medical or surgical episode and have been transferred for sub-acute care. This may include sub-acute care in rehabilitation and convalescent care units where indicated.

ii) Payable 2 times per patient per week to a maximum of 90 days. In higher acuity situations, a note record explaining the medical necessity is required if additional visits are necessary.

T13148 Sub-acute hospital visit - 1st visit of the day 62.62

Notes:

i) Payable only for first patient seen for sub-acute care on any calendar day.

iv) Essential non-emergent additional visits to a patient receiving sub-acute care by the attending or replacement physician during one day are to be payable under fee item 12148. The claim must include the time of each visit and statement of need included in a note record. For daytime emergency visit, see fee item 00112.

The following modification to the payment schedule has been approved effective April 1, 2008:

New Fee Items

13008 Community GP Hospital Visit $39.14

This item is payable only to the General Practitioner or practice group that accepts the role of being Most Responsible for longitudinal, coordinated care of that patient.

Notes:

i) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108. The claim must include the time of each visit and a statement of need included a note record. For daytime emergency visit, see fee item 00112

ii) Billable by Community based GP's with full hospital privileges for daily attendance on the patients they have most responsibility for.

iii) Not billable by physicians who have billed a specialty consult in the previous 12 months.

iv) Not payable to physicians who are employed by or who are under contract whose duties would otherwise include provision of this care.

13028 Community GP Supportive Care Hospital Visit $33.13

This item is payable only to the General Practitioner or practice group that accepts the role of being Most Responsible for longitudinal, coordinated care of that patient.

Notes:

i) Referring physician may charge one hospital visit for each day hospitalized and thereafter one visit for every seven days hospitalized.

ii) Billable by Community based GPs with full hospital privileges for supportive care for the patients admitted to hospital under care of a specialist.

iii) Not billable by physicians who have billed a specialty consult in the previous 12 months.

iv) Not payable to physicians who are employed by or who are under contract whose duties would otherwise include provision of this care.

v) Not payable to physicians working under salary, service contracts or sessional arrangements and whose duties would otherwise include provision of this care.

The following modifications to the Payment Schedule have been approved by the MSC, effective December 31, 2007:

Deleted Fee Items

G14030 Major Complex Care Plan $100.00
This fee is payable upon the development and documentation of the patient's Complex Care Plan as stated above.
Notes:
i) Payable once per calendar year;
ii) Payable in addition to a visit fee billed same day;
iii) Visit fee to indicate face-to-face interaction with patient same day must accompany billing.
iv) Not payable on same day as G14031, G14032 on same patient;
v) Not payable in the same calendar year as G14033, 13134, 13135, 13136, 13137 or 13138
vi) G14016, community conferencing fee payable on same day for same patient, if all criteria met
vii) CDM fees G14050/G14051 payable on same day for same patient, if all other criteria met

G14031 Minor Complex Care Plan $75.00
This fee is payable upon completion and documentation of a significant review of the eligible patient's Major Complex Care Plan, with any modifications to that plan recorded in the patient's chart.
Notes:
i) Not payable unless the Major Complex Care Plan has been previously billed in the same calendar year;
ii) Payable once per calendar year;
iii) Payable in addition to a visit fee billed same day;
iv) Visit fee to indicate face-to-face interaction with patient same day must accompany billing.
v) Not payable on same day as G14030, G14032 on same patient;
vi) Not payable in same calendar year as G14033, 13134, 13135, 13136, 13137or 13138
vii) G14016, community conferencing fee payable on same day for same patient, if all criteria met
viii) CDM fees G14050/G14051 payable on same day for same patient, if all other criteria met

G14032 Complex Care Follow-Up $35.00
This fee is payable upon review of an eligible patient's clinical status with minor review of the Complex Care Plan.
Notes:
i) Payable a maximum of 4 times per calendar year;
ii) Not payable unless the Major Complex Care Plan has been previously billed in the same calendar year;
iii) Payable in addition to a visit fee billed same day;
iv) Visit fee to indicate face-to-face interaction with patient same day must accompany billing.
v) Not payable on same day as G14030, G14031 on same patient;
vi) Not payable in same calendar year as G14033, 13134, 13135, 13136, 13137 or 13138
vii) G14016, community conferencing fee payable on same day for same patient, if all criteria met
viii) CDM fees G14050/G14051 payable on same day for same patient, if all other criteria met

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective January 1, 2008:

Amendment

The following fee item description is hereby amended, effective as indicated:

G14033 Annual Complex Care management Fee $315.00

The Complex Care Management Fee is advance payment for the complexity of caring for patients with two of the eligible conditions and is payable upon the completion and documentation of the Complex Care Plan for the management of the complex care patient during that calendar year.

A Complex care plan requires documentation of the following elements in the patient's chart that:

1. There has been a detailed review of the case/chart and of current therapies
2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Complex care Management fee is billed
3. Specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee
4. Incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the complex care fee
5. Outlines expected outcomes as a result of this plan, including end-of-life issues when clinically appropriate
6. Outlines linkages with other health care professionals that would be involved in the care, their expected roles
7. Identifies an appropriate time frame for re-evaluation of the plan
8. Confirms that the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved health professionals as indicated.

Notes:

i) Payable once per calendar year
ii) Payable in addition to office visits, CPx, or home visits with patient on the same day, which must accompany billing
iii) Visit or CPx fee to indicate face-to-face interaction with patient same daymust accompany billing
iv) G14016, Community Patient Conferencing Fee, payable on same day for same patient, if all criteria met
v) G14015, Facility Patient Conferencing Fee, not payable on the same day for the same patient, as facility patients not eligible
vi) CDM fees G14050/ G14051/ G14052 payable on same day for same patient, if all other criteria met
vii) Minimum required time 30 minutes in addition to visit time same day
viii) Maximum of 5 complex care fees per day per physician unless exemption given
ix) Not payable for patients seen in locations other than the office, home or assisted living residence where no professional staff on site.

New Fee Item

The following fee item is hereby added, effective as indicated:

G14039 Complex Care Telephone/Email Follow-up Management.....$15.00

This fee is payable for follow-up management, via 2-way telephone or email communication, of patients for whom a Complex Care Management Fee (G14033) has been paid. Access to this fee is restricted to the GP that has been paid for the Complex Care Management Fee (G14033) and is therefore Most Responsible GP (MRGP) for the care of that patient for the submitted chronic conditions for that calendar year. The only exception would be if the billing GP has the approval of the Most Responsible GP, and this must be documented as a note entry accompanying the billing. As with all clinical services, dates of service under this item should be documented in the patient record together with the name of the person who communicated with the patient or patient's medical representative as well as a brief notation on the content of the communication.

Notes:

i) Payable a maximum of 4 times per calendar year per patient

ii) Not payable unless the GP/FP is eligible for and has been paid for the Annual Complex Care Management Fee (G14033) during the same calendar year

iii) Telephone or e-mail management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not billable for simple notification of office appointments

iv) Payable only to the physician that has successfully billed for the Annual Complex Care Management Fee (G14033) unless the billing physician has the approval of the GP responsible for the Annual Complex Care Management Fee (G14033) and a note entry is submitted indicating this

v) G14016, Community Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement for the G14016

vi) Not payable on the same calendar day as a visit fee by the same physician for the same patient

vii) Chart entry requires the capture of the name of the person who communicated with the patient or patient's representative as well as capture of the elements of care discussed.

The following modifications to the Payment Schedule have been approved effective December 31, 2007:

Deleted Fee Items

The following fee items are deleted, effective as indicated:

P13134 Annual complex care block fee (age 0-1).....$184.14
P13135 Annual complex care block fee (age 2-59).....$167.40
P13136 Annual complex care block fee (age 60-69).....$192.48
P13137 Annual complex care block fee (age 70-79).....$209.22
P13138 Annual complex care block fee (age 80+).....$217.62

Notes:

i) Payable once per calendar year;

ii) Not payable in same calendar year as G14030, G14031, G14032 on same patient;

iii) *Annual Complex Care Fee (14033) must be billed on same date of service;*
iv) *A Complex Care Plan must have been created, recorded in the patient's chart, and communicated to the patient and/or the patient's medical representative prior to billing for the advance block payments;*
v) *The advance block payment covers the provision of all services provided to that individual patient for the two qualifying conditions submitted;*
vi) *Age category for patient is determined by the age of the patient on the date the block fees are billed (Date of Service);*
vii) *Complete physical examinations are payable in addition when medically indicated;*
viii) *Acute and sub-acute hospital visit fees are payable in addition;*
ix) *G14016, community conferencing fee payable on same day for same patient, if all criteria met.*
x) *CDM fees G14050/G14051 payable on same day for same patient, if all other criteria met;*
xi) *Service must be provided by June 30 in the calendar year.*

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective January 1, 2008:

New Fee Items:

G14043 GP Mental Health Planning Fee $100.00

This fee is payable upon the development and documentation of a patient's Mental Health Plan for patients resident in the community (home or assisted living, excluding care facilities) with a confirmed Axis I diagnosis of sufficient severity and acuity to cause interference in activities of daily living and warrant the development of a management plan.

This fee requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, and use of appropriate validated assessment tools, with confirmation of diagnosis through DSM IV diagnostic criteria. It requires a face-to-face visit with the patient, with or without the patient's medical representative.

From these activities (review, assessment, planning and documentation) a Mental Health Plan for that patient will be developed that documents in the patient's chart:

- That there has been a detailed review of the patient's chart/history and current therapies;
- The patient's mental health status and provisional diagnosis by means of psychiatric history and mental state examination;
- The use of and results of validated assessment tools. GPSC strongly recommends that these evaluative tools, as clinically indicated, be kept in the patient's chart for immediate accessibility for subsequent review. Assessment tools such as the following are recommended, but other assessment tools that allow risk monitoring and progress of treatment are acceptable:
  - i) PHQ9, Beck Inventory, Ham-D for depression;
  - ii) MMSE for cognitive impairment;
  - iii) MDQ for bipolar illness;
  - iv) GAD-7 for anxiety;
  - v) Suicide Risk Assessment;
  - vi) Audit (Alcohol Use Disorders Identification Test) for Alcohol Misuse;
- DSM-IV Axis I confirmatory diagnostic criteria;
- A summary of the condition and a specific plan for that patient's care;

- An outline of expected outcomes;
- Outlined linkages with other health care professionals (Including Community Mental Health Resources and Psychiatrists, as indicated and/or available) who will be involved in the patient's care, and their expected roles;
- An appropriate time frame for re-evaluation of the Mental Health Plan;
- That the developed plan has been communicated verbally or in writing to the patient and/or the patient's Medical Representative, and to other health professionals as indicated.

Notes:

i) Requires documentation of the patient's mental health status and diagnosis by means of psychiatric history, mental state examination, and confirmatory DSM IV diagnostic criteria. Confirmation of Axis I Diagnosis is required for patients eligible for the GP Mental Health Planning Fee. Not intended for patients with self limiting or transient mental health symptoms (e.g. Brief situational adjustment reaction, normal grief, life transitions) for whom a plan for longer term mental health care is not necessary.

ii) Payable once per calendar year per patient;

iii) Payable in addition to a visit fee billed same day;

iv) Minimum required time 30 minutes in addition to visit time same day;

v) G14016, Community conferencing fee payable on same day for same patient, if all criteria met;

vi) Not payable on the same day as G14045, G14046, G14047, G14048 (GP Mental Health Management Fees);

vii) Not payable on the same day as G14049 (GP Mental Health Telephone/Email Management fee)

viii) Not intended as a routine annual fee if the patient does not require ongoing Mental Health Plan review and revision;

ix) G14015, Facility Patient Conferencing Fee, not payable on same day for same patient as facility patients are not eligible.

G14045	GP Mental Health Management Fee age 2–59	$50.31
G14046	GP Mental Health Management Fee age 60–69	$57.86
G14047	GP Mental Health Management Fee age 70–79	$62.89
G14048	GP Mental Health Management Fee age 80+	$65.41

These fees are payable for GP Mental Health Management required beyond the four MSP counselling fees (age-appropriate 00120 fees billable under the MSC payment schedule) for patients with a chronic mental health condition on whom a Mental Health Plan has been created and billed.

Notes:

i) Payable a maximum of 4 times per calendar year per patient;

ii) Payable only if the Mental Health Planning Fee (G14043) has been previously billed and paid in the same calendar year by the same physician;

iii) Payable only to the physician paid for the GP Mental Health Planning Fee (G14043), unless that physician has agreed to share care with another delegated physician;

iv) Not payable unless the age-appropriate 00120 series has been fully utilized;

v) Minimum time required is 20 minutes;

vi) Not payable on same day as G14043 (GP Mental Health Planning Fee), or G14049 (GP Mental Health Telephone/Email Management Fee);

vii) G14016 (Community Patient Conferencing Fee) payable on same day for same patient if all criteria met;

viii) G14015 (Facility Patient Conferencing Fee) not payable on same day as facility patients not eligible;

ix) CDM fees (G14050, G14051, G14052) payable if all criteria met.

G14049 GP Mental Health Telephone/Email Management Fee.....$15.00
This fee is payable for two-way communication with eligible patients via telephone or email for the provision of clinical follow-up management by the GP who has created and billed for the GP Mental Health Planning Fee (G14043). This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

i) Payable to a maximum of five times per calendar year per patient;
ii) Not payable unless the GP/FP is eligible for and has been paid for the GP Mental Health Planning Fee (G14043) during the same calendar year;
iii) Telephone/Email Management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not payable for simple notification of office appointments;
iv) Payable only to the physician paid for the GP Mental Health Planning Fee (G14043) unless that physician has agreed to share care with another delegated physician;
v) G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement for the G14016;
vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016;
vii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed;

Eligibility for G14043, G14045, G14046, G14047, G14048, G14049

- Eligible patients are community based, living in their home or assisted living. Facility based patients are <u>not</u> eligible.
- Payable only to the GP or practice group that accepts the role of being Most Responsible for the longitudinal, coordinated care of the patient for that calendar year;
- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months;
- Not payable to physicians who are employed by or who are under contract whose duties would otherwise include provision of this care;
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective as indicated:

Deleted Fee Item

The following fee item is hereby deleted, effective March 31, 2008:

Surgical Assistance - Total operative fee(s) for procedure(s):

00194 - less than $105.00

Amendment

The following fee item description is hereby amended, effective April 1, 2008:

Surgical Assistance - Total operative fee(s) for procedure(s):

00195 - less than $314.00 inclusive

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective as indicated:

Amendment

The following fee item description is hereby revised, effective April 1, 2006 to March 31, 2008:

00104 Extra patients seen during same house call – up to a maximum of two extra patients

Deleted Fee Item

The following fee item is hereby deleted, effective April 1, 2008:

00104 Extra patients seen during same house call – up to a maximum of two extra patients

Amendment

The following note is hereby added to the indicated fee item, effective April 1, 2008:

00103 Home visit – (call placed between 0800 and 1800 hours).
Note: *Additional patients seen during same house call are to be billed under the applicable out of office visit fee items (12200, 13200, 16200, 17200, 18200).*

Anesthesia

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective April 1, 2006:

Amendment

The payment rates for the following Anesthesia items are hereby amended as indicated. These modifications will be monitored for a period of one year, effective September 1, 2007 to August 31, 2008. After this time, they will be adjusted retroactively and prospectively to ensure that the actual monetary impact equals the expected impact.

Visit / Evaluation

01107 Office visit 49.42
01108 Hospital visit 41.19
Note: *01107 and 01108 are not paid with other listings.*

Referred Cases

Consultations

01016 **Consultation by a certified specialist in Anesthesia:**
For diagnostic opinion and/or therapeutic management of complicated chronic pain, and/or related problems. To include comprehensive history and physical examination, review of radiological and laboratory findings and a written report. If followed by a diagnostic or therapeutic nerve block the consultation may be charged in addition to the nerve block fees on the first occasion 175.70

01116	**Repeat or limited consultation by a certified specialist in Anesthesia:** To apply for a diagnostic opinion and/or therapeutic pain management where a consultation is repeated for the same condition/problem within six months by the same consultant, or where in the judgment of the consultant, the consultative service does not warrant a 01016	87.83

Diagnostic and Therapeutic Anesthesia Fee Items

01022	Nerve plexus	117.99
T01124	Peripheral nerve block – single	55.89
T01125	Peripheral nerve block – multiple	84.46
01035	Gasserian ganglion	221.59
	Epidural Blocks:	
01135	Lumbar	130.94
01036	Thoracic	198.59
01037	Cervical	229.15
01138	Caudal blocks	130.94
	Nerve Root or Racet Blocks:	
	Cervical:	
01140	- single	159.49
01141	- multiple	212.65
	Thoracic:	
01142	- single	146.06
01143	- multiple	194.75
	Lumbar:	
01144	- single	132.65
01145	- multiple	176.88
	Subarachnoid (Spinal) Blocks:	
01032	Subdural (spinal)	139.36
01034	Differential spinal	185.82
	Sympathetic Nerves:	
01040	Stellate ganglion	102.69
01042	Paravertebral (lumbar sympathetic)	168.83
01044	Coeliac plexus	235.00
	Permanent Cryosection and/or Neurolysis:	
01146	Major plexus or nerve root	307.29
01147	Single peripheral nerve	145.33
01148	Multiple peripheral nerves	194.75
01149	Epidural or subarachnoid neurolysis	345.79
01150	Gasserian ganglion neurolysis	345.79
	Injection Tendon Sheath, Ligaments, Trigger Points:	
01156	Single injection	52.92
01157	Multiple injections	66.35
T01159	IV injection for diagnosis and/or therapeutic management of pain syndromes – local anesthetic only	52.92

T01160 IV injections for diagnosis and/or therapeutic management of pain syndromes – guanethidine or bretylium only.....105.84

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective October 1, 2005:

Amendment:

The cancellation dates of the following provisional item have been extended until September 30, 2009, or when replaced by a subsequent Minute, whichever occurs first:

Section of Anesthesia

P01105 Anesthesia for cataract surgery - per 1 minute increment $2.00
***Note**: This item applies to fee codes 02188, 02190, 02192, 02196 and 22191.*

P01165 Patients 80 years of age and over.....$36.20

Dermatology

The following modification to the Payment Schedule has been approved, effective January1, 2006:

Amendment

The cancellation date of the following provisional item has been extended until December 31, 2009, or when replaced by a subsequent minute, whichever occurs first:

P00228 Photo epilation of facial hair-per ¼ hour (or major portion thereof) $27.88
Notes:
i) Billable to a maximum of ½ hour per session
ii) Epilation of facial hair for familial hirsutism is not a benefit of the Plan
iii) Pre-authorization is required (see Preamble B.16.2. (6))

The cancellation dates of the following provisional items have been extended. This Minute will expire on January 31, 2009 or when replaced by a subsequent Minute, whichever occurs first:

P20210 Telehealth Consultation: To include history and dermatological examination, with review of any previous X-ray and laboratory findings and written report.....52.95

P20214 Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee (laboratory test and biopsy when necessary, extra) 36.15
***Note**: Punch and shave biopsies are included in consultation or visit fees.*

P20207 Telehealth subsequent office visit 21.89

P20208 Telehealth subsequent hospital visit 20.87

Ophthalmology

In accordance with Section 26(3) of the *Medicare Protection Act*, the following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective July 1, 2007:

Amendments:

The cancellation dates of the following provisional items have been extended. This Minute will expire on June 30, 2008 or when replaced by a subsequent Minute, whichever occurs first:

P22067	Computerized retinal nerve fibre layer photography and neuro-retinal rim assessment (e.g.: Heidelberg, GDX)	63.92
P22068	- professional fee	12.28
P22069	- technical fee	51.64

Notes:

i) Requires both qualitative and quantitative assessments.

ii) Includes examination of both eyes whether at one time or two separate visits.

iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.

Amendment:

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective January 1, 2008:

P22125	Photodynamic therapy for age-related wet macular degeneration - professional fee *Note: Payable to Retinal Physicians certified in PDT treatment only.*	$274.39

The cancellation dates of the following provisional items have been extended. This Minute will expire on January 31, 2009 or when replaced by a subsequent Minute, whichever occurs first:

P22010	Telehealth Consultation: To include history, eye examination, measurement for refractive error, ophthalmoscopy, biomicroscopy, tonometry, eye-balance test, keratometry, where indicated and necessary to prepare a written report	71.37
P22011	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit to the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	47.89
P22007	Telehealth subsequent office visit	27.58
P22008	Teleheatlh subsequent hospital visit	21.72

General Internal Medicine

In accordance with Section 26(3) of the *Medicare Protection Act*, the following modification to the Payment Schedule has been approved by the Medical Services Commission, effective immediately.

Deleted Fee Items:

The following fee item is hereby deleted:

S00735	Laryngogram – procedural fee	$24.78

The cancellation date of the following provisional item has been extended until October 31, 2008.

P10708 Video Capsule endoscopy using M2A capsule – professional fee $250.00

Notes:

i) Payable for gastrointestinal bleeding suspected to originate in the small intestine, and only after investigations have ruled out other causes.

ii) Limited to services rendered at St.Paul's Hospital, Vancouver only.

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective July 31, 2007:

Deleted Fee Items:

The following fee items are hereby deleted:

00301 Comprehensive geriatric assessment – limited to patients aged 75 years and over 217.85

00302 Geriatric reassessment subsequent to comprehensive assessment – limited to patients aged 75 years and over 59.62

Notes:

i) 00301 and 00302 are payable only to internists with a certificate of special competence in Geriatric Medicine from the Royal College of Physicians and Surgeons of Canada.

ii) 00301 and 00302 are applicable to the assessment of geriatric patients who have multiple physical, mental and/or social problems; who often require a collateral history from physicians, other health care givers and family; and for whom community services may be required. Includes diagnostic interview and examination, including cognitive, functional and social assessment, review of X-ray, laboratory and other relevant records, treatment recommendations and a written report.

Examinations by Certified Internist

00316 Electrocardiogram and interpretation – office, each 24.05

00317 - home, each 33.45

00318 Electrocardiogram – professional fee 8.42

00325 Cardioversion 79.10 2

***Note**: The procedural fee does not include the consultation fee or follow-up daily visits. If more than one cardioversion is performed on any patient in a single day, this is to be treated as a special case and a written report should accompany the account.*

Single chamber permanent programmable pacemaker testing

00326 - professional fee 45.36

00353 - technical fee 22.68

Dual chamber permanent programmable pacemaker testing

00328 - professional fee 68.02

00354 - technical fee 45.36

***Note:** 00326, 00353, 00328, 00354 include office visit and necessary ECG, and may be billed by any qualified physician.*

00332 Pacemaker standby and/or placement of the endocardial catheter 79.10 4

00333 Generator placement and venous cutdown 258.25 4

00334 Graded exercise test (performance and interpretation) 73.06

00335 - professional fee 43.34

00336 - technical fee 29.72

Notes:

i) This test involves controlled graduated exercise levels by the use of either a bicycle or treadmill ergometer or pharmaceutical agents, with continuous electrocardiographic monitoring during and after exercise. At least two exercise work levels must be measured, exclusive of a warm-up period, and reproducible exercise and post-exercise records must be obtained.

ii) When only one level of exercise testing is performed, then the same fee as for a Master 2-step should apply.

iii) When a 12-lead cardiogram is done on the same day as the graded exercise test, it is included in Item 00334.

iv) A graded exercise tolerance test may be repeated once within one year to assess the functional capacity of the patient after recovery from coronary bypass surgery and to assess the effect of therapy where exercise has produced a serious ventricular rhythm disturbance. In all other circumstances, where graded exercise tests are repeated within one year, a letter of explanation for the need will accompany the account to the Plan, except in conjunction with thallium myocardial scans where a graded exercise test may be performed and charged with each scan.

v) Where the exercise stress test (00334, 00335, 00336) and exercise echocardiogram (08662) are performed by the same physician, the stress test will be paid at 50 percent.

00337 Replacement transfusion – hepatic failure to include two weeks' care after transfusion 282.31

Note: *Consultation and necessary hospital visits prior to initial transfusion extra.*

00338 Plasmapheresis -- therapeutic 112.59

Scanning of 24 hour electrocardiogram

00347 - professional fee 64.86

00348 - technical fee 24.33

Technical fee for scanning

00349 **Level 1:** Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing edited trend analysis, and/or edited graphic or alpha-numeric hourly summary of data 53.12

00363 **Level 2:** Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing unedited trend analysis, and/or unedited graphic or alpha-numeric hourly summary of data 39.83

00364 **Level 3:** Requires a recorder capable of recording only a portion of each minute, or a pre-determined time period after an abnormal complex is sensed. The scanner of this record is capable of analyzing the data and printing all beats in the pre-determined time period and analyzing the ST segment, heart rate and ectopic beat frequency 26.63

00365 **Level 4:**

i) Requires a recorder capable of recording beats for only a portion of a minute and feeding this information into a scanner through an adaptor that feeds the information to the standard ECG machine;

ii) Requires a recorder capable of recording all beats and feeding the information into an alpha-numeric device which prints an hourly summary of heart rate, minimum and maximum R-R intervals, premature beats, and ventricular complexes of adnormal width 13.31

Patient Activated Cardiac Event Recorders

P00362 Event/unmonitored loop recorders (first strip)
- professional fee 35.52

P00369 - each additional strip (per strip) 17.76

Note: *Additional Strips are limited to two extra strips per patient, per two-week period.*

00392 Event/unmonitored loop recorder – technical fee 42.68

Notes:

i) The following notes apply to fee items 00362, 00369, 00392
ii) These items are intended to cover a two-week period
iii) Consultation not paid in addition
iv) Provide note record when more than one recording billed per patient, per year
v) Holter monitor not payable in addition
vi) An explanatory note is required for second test, same patient.

Intracardiac Electrophysiological Mapping

00366 - initial study 761.24 4

00368 Oesophageal or intra-atrial electro-physiological study 113.80 4

Electrophysiological Mapping and Ablation

T00385 Catheter ablation – AV node 930.31 4

Note: *To include diagnostic study (00366).*

T00386 Catheter ablation of SVT 1,422.82 4

Note: *To include diagnostic study (00366).*

T00387 Catheter ablation of VT 1,532.27 4

Note: *To include diagnostic study (00366).*

T00388 Repeat EP study 328.34 4

Note: *Not normally to be billed for re-check on the same day.*

Note: *Follow-up visits are billable in addition to fee items T00385, T00386, T00387 and T00388.*

T00389 Catheter ablation - assistants fee (per hour) 136.81

Notes:

i) For SVT and/or VT ablation; AV node may be billed with supporting documentation.
ii) Applicable only to fully qualified cardiologists with 2 years EP training.

Chemotherapy

00381 High intensity cancer chemotherapy: to include admission history and physical examination, review of pertinent laboratory and radiological data, counselling of patient and/or family, venisection and institution of an intravenous line, and administration of a parenteral chemotherapeutic program which must be given on an in-patient basis 146.10

Note: *This service is not payable more frequently than once every 28 days. The following treatments fall into this category:*

a) chemotherapy for acute leukemia;
b) chemotherapy utilizing cisplatinum given in a dose exceeding 50 mg/m2 per treatment;
c) chemotherapy utilizing isophosphamide in combination with bladder protector Mesna;
d) chemotherapy using DTIC in a dose exceeding 100 mg/m2;
e) chemotherapy utilizing methotrexate in dose exceeding 1 g/m2 (and combined with the folinic acid rescue regimen);
f) chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol.)

00382 **Major Cancer Chemotherapy**:

To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line and administration of multiple parenteral chemotherapeutic agents 85.69

***Note**: This service is not payable more than once every 7 days.*

00383 **Limited Cancer Chemotherapy**:

To include the administration of single parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line 48.97

***Note:** This item is not payable more than once every 7 days. Neither is it to be billed for routine IV push administration of 5-flourouracil as a single agent.*

Miscellaneous

00330	Temporary right ventricular pacemaker catheter placement, using external battery pack – internist or other qualified physician	156.97	4
00370	Dilation of oesophagus	55.76	3
00371	- repeat within one month	33.67	3
	Colonoscopy with flexible colonoscope:		
00373	- biopsy	229.07	2
00374	- removal polyp	342.47	2
00393	Percutaneous endoscopically placed feeding tube (PEG) – procedural fee	159.28	3
00394	Assistant fee for PEG procedure	109.56	
00390	Care of renal transplant patient, including immediate preparation and fourteen days post-operative care	1015.65	

Diagnostic Ultrasound

***Note:** Real-time ultrasound fees may only be claimed for studies performed when a physician is on site in the laboratory for the purpose of diagnostic ultrasound supervision.*

ST00357 Trans-esophageal echocardiography (Procedure fee) 86.33 3

Notes:

i) This procedure fee is intended to cover all aspects of the patient's cardiological care during the performance of the TEE. A consultation may not be billed in addition, except in situations where specifically requested and the physician fulfills all Preamble criteria for billing a consultation

ii) Trans-thoracic echocardiography may only be billed in addition where medically indicated. Written explanation is required.

00391 Echocardiography – combined two dimensional real time and M-mode 141.42

Dialysis Fees

(A) Acute renal failure (haemodialysis):

00350	Blood dialysis – physician in charge	456.44
00351	Repeat blood dialysis - physician in charge	171.53

Notes:

i) Maximum number of repeat dialysis on one patient is four. Thereafter bill as chronic renal failure, under fee item 00358.

ii) When Items 00350 or 00351 are charged, there should be no charge under items 00310, 00308, or 00081.

00352 Blood dialysis - fee for cut down by surgeon to be charged in addition to items 00350 or 00351 ..... 115.39

B) Acute renal failure (peritoneal dialyisis):

00355 Dialysis (initial), to include consultation and two weeks care 341.49

00356 Reinsertion of peritoneal catheter after 10 days from initial insertion 44.86

Note:

Item 00081 not to be charged in addition to item 00355. Where an initial peritoneal dialysis is performed and for various reasons, haemodialysis initiated within next 48 hours, the subsequent service should be charged under item 00358 plus item 00356 for the insertion of catheter.

(C) Chronic renal failure:

(a) <u>Haemodialysis:</u>

00358 Performance of haemodialysis – fee to include supervision of the procedure, history, physical examination, appropriate adjustment of solutions, and other problems during dialysis, for each dialysis 44.86

Note:

Other medical situations which may arise such as septicaemia, etc., to be covered by item 00081 and always to be accompanied by an explanation when billing the Plan.

(b) <u>Peritoneal Dialysis:</u>

00323 Performance of initial peritoneal dialysis to include consultation and two weeks' care 341.49

00359 Performance of each peritoneal dialysis thereafter, - fee to include supervision of procedure, history, physical examination, appropriate adjustments of solutions, and any other problem that may arise during dialysis 44.86

Notes:

i) Other situations requiring medical care such as bacteriaemias, etc., to be covered by item 00081 in the Payment Schedule and always to be accompanied by an explanation.

ii) If a period greater than three months elapses since last dialysis, then charge as initial dialysis 00355.

Home Dialysis

00361 Supervision of home dialysis - per week 54.23

Note:

This fee item covers all services per week necessary for home or limited care dialysis and includes consultations and visits of all types. Should a patient take ill with a condition totally unrelated to renal care or require hospitalization for any reason, then other appropriate fee items may be billed in lieu of fee item 00361.

Cardiology

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective August 1, 2007:

New Fee Items:

The following new listings, descriptions and notes are effective as indicated:

The following note is added subsequent to the Sectional heading:

These listings cannot be correctly interpreted without reference to the Preamble, please refer to the appropriate section in the Medical Services Commission Payment Schedule available on the MSP web site at: http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html

Referred Cases

33010	**Consultation**: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	137.05
33012	**Repeat or limited consultation**: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	65.80
33014	Prolonged visit for counselling (maximum, four per year) ***Note:*** *See Preamble, Clause B.4.c.*	44.80

Group counselling for groups of two or more patients:

33013	- first full hour	91.75
33015	- second hour, per 1/2 hour or major portion thereof	45.85

Continuing care by consultant:

33006	Directive care	38.19
33007	Subsequent office visit	39.89
33008	Subsequent hospital visit	23.51
33009	Subsequent home visit	41.97
33005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time call placed.*	93.00

Examinations by Certified Cardiologist

33016	Electrocardiogram and interpretation – office, each	24.05
33017	- home, each	33.45
33018	Electrocardiogram – professional fee	8.42
33025	Cardioversion ***Note:*** *The procedural fee does not include the consultation fee or follow-up daily visits. If more than one cardioversion is performed on any patient in a single day, this is to be treated as a special case and a written report should accompany the account.*	79.10 2
	Single chamber permanent programmable pacemaker testing	
33026	- professional fee	45.36
33053	- technical fee	22.68
	Dual chamber permanent programmable pacemaker testing	
33028	- professional fee	68.02

33054 - technical fee 45.36

Note: *33026, 33053,33028,33054 include office visit and necessary ECG, and may be billed by any qualified physician.*

33030 Temporary right ventricular pacemaker catheter placement, using external battery pack – cardiologist or other qualified physician 156.97 4

33032 Pacemaker standby and/or placement of the endocardial catheter 79.10 4

33033 Generator placement and venous cutdown 258.25 4

33034 Graded exercise test (performance and interpretation) 73.06

33035 - professional fee 43.34

33036 - technical fee 29.72

Notes:

ii) This test involves controlled graduated exercise levels by the use of either a bicycle or treadmill ergometer or pharmaceutical agents, with continuous electrocardiographic monitoring during and after exercise. At least two exercise work levels must be measured, exclusive of a warm-up period, and reproducible exercise and postexercise records must be obtained.

ii) When only one level of exercise testing is performed, then the same fee as for a Master 2-step should apply.

iii) When a 12-lead cardiogram is done on the same day as the graded exercise test, it is included in Item 33034.

vi) A graded exercise tolerance test may be repeated once within one year to assess the functional capacity of the patient after recovery from coronary bypass surgery and to assess the effect of therapy where exercise has produced a serious ventricular rhythm disturbance. In all other circumstances, where graded exercise tests are repeated within one year, a letter of explanation for the need will accompany the account to the Plan, except in conjunction with thallium myocardial scans where a graded exercise test may be performed and charged with each scan.

v) Where the exercise stress test (33034, 33035, 33036) and exercise echocardiogram (08662) are performed by the same physician, the stress test will be paid at 50 percent.

33037 Replacement transfusion – hepatic failure to include two weeks' care after transfusion 282.31

Note: *Consultation and necessary hospital visits prior to initial transfusion extra.*

Scanning of 24 hour electrocardiogram

33047 - professional fee 64.86

33048 - technical fee 24.33

Technical fee for scanning

33049 **Level 1:** Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing edited trend analysis, and/or edited graphic or alpha-numeric hourly summary of data 53.12

33063 **Level 2:** Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing unedited trend analysis, and/or unedited graphic or alpha-numeric hourly summary of data 39.83

33064 **Level 3:** Requires a recorder capable of recording only a portion of each minute, or a pre-determined time period after an abnormal complex is sensed. The scanner of this record is capable of analyzing the data and printing all beats in the pre-determined time period and analyzing the ST segment, heart rate and ectopic beat frequency 26.63

33065 **Level 4:**

i) Requires a recorder capable of recording beats for only a portion of a minute and feeding this information into a scanner through an adaptor that feeds the information to the standard ECG machine;

ii) Requires a recorder capable of recording all beats and feeding the information into an alpha-numeric device which prints an hourly summary of heart rate, minimum and maximum R-R intervals, premature beats, and ventricular complexes of adnormal width 13.31

Patient Activated Cardiac Event Recorders

P33062 Event/unmonitored loop recorders (first strip)
- professional fee 35.52

P33069 - each additional strip (per strip) 17.76

Note: *Additional Strips are limited to two extra strips per patient, per two-week period.*

P33092 Event/unmonitored loop recorder – technical fee 42.68

Notes:

i) The following notes apply to fee items 33062, 33069, 33092
ii) These items are intended to cover a two-week period
iii) Consultation not paid in addition
iv) Provide note record when more than one recording billed per patient, per year
v) Holter monitor not payable in addition
vi) An explanatory note is required for second test, same patient.

Intracardiac Electrophysiological Mapping

33066 - initial study 761.24 4

33068 Oesophageal or intra-atrial electro-physiological study 113.80 4

Electrophysiological Mapping and Ablation

T33085 Catheter ablation – AV node 930.31 4

Note: *To include diagnostic study (33066).*

T33086 Catheter ablation of SVT 1,422.82 4

Note: *To include diagnostic study (33066).*

T33087 Catheter ablation of VT 1,532.27 4

Note: *To include diagnostic study (33066).*

T33088 Repeat EP study 328.34 4

Note: *Not normally to be billed for re-check on the same day.*

Note: *Follow-up visits are billable in addition to fee items T33085, T33086, T33087 and T33088*

T33089 Catheter ablation - assistant's fee (per hour) 136.81

Notes:

i) *For SVT and/or VT ablation; AV node may be billed with supporting documentation.*
ii) *Applicable only to fully qualified cardiologists with 2 years EP training.*

Diagnostic Ultrasound

Note: *Real-time ultrasound fees may only be claimed for studies performed when a physician is on site in the laboratory for the purpose of diagnostic ultrasound supervision.*

ST33057 Trans-esophageal echocardiography (procedure fee) 86.33 3

Notes:

i) This procedure fee is intended to cover all aspects of the patient's cardiological care during the performance of the TEE. A consultation may not be billed in addition, except in situations where specifically requested and the physician fulfills all Preamble criteria for billing a consultation.
ii) Trans-thoracic echocardiography may only be billed in addition where medically indicated. Written explanation is required.

33091 Echocardiography – combined two dimensional real time and M-mode.....141.42

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective immediately:

Amendment:

The wording of the following fee item description is hereby modified as indicated:

T33088 Repeat diagnostic EP study..... 328.34 4
Note: *Not normally to be billed for re-check on the same day.*

The following modification to the Payment Schedule has been approved, effective August 1, 2007:

Amendment

The "Y" prefix (designates office or hospital visit on the same day extra to procedure fee is hereby added to the following fee item:

Y33025 Cardioversion $79.10 2
Note: *The procedural fee does not include the consultation fee or follow-up daily visits. If more than one cardioversion is performed on any patient in a single day, this is to be treated as a special case and a written report should accompany the account.*

Endocrinology and Metabolism

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective August 1, 2007:

New Fee Items:

The following new listings, descriptions and notes are effective as indicated:

The following note is added subsequent to the Sectional heading:

These listings cannot be correctly interpreted without reference to the Preamble, please refer to the appropriate section in the Medical Services Commission Payment Schedule available on the MSP web site at: http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html

Referred Cases

33210 **Consultation**: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report.....137.05
33212 **Repeat or limited consultation**: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee.....65.80
33214 Prolonged visit for counselling (maximum, four per year).....44.80
Note: *See Preamble, Clause B.4.c.*

Group counselling for groups of two or more patients:

33213 - first full hour.....91.75
33215 - second hour, per 1/2 hour or major portion thereof.....45.85

Continuing care by consultant:

33206	Directive care	38.19
33207	Subsequent office visit	39.89
33208	Subsequent hospital visit	23.51
33209	Subsequent home visit	41.97
33205	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time call placed.*	93.00

Gastroenterology

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective August 1, 2007:

New Fee Items:

The following new listings, descriptions and notes are effective as indicated:

The following note is added subsequent to the Sectional heading:
These listings cannot be correctly interpreted without reference to the Preamble, please refer to the appropriate section in the Medical Services Commission Payment Schedule available on the MSP web site at: http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html

Referred Cases

33310	**Consultation**: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	137.05
33312	**Repeat or limited consultation**: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	65.80
33314	Prolonged visit for counselling (maximum, four per year) ***Note:*** *See Preamble, Clause B.4.c.*	44.80

Group counselling for groups of two or more patients:

33313	- first full hour	91.75
33315	- second hour, per 1/2 hour or major portion thereof	45.85

Continuing care by consultant:

33306	Directive care	38.19
33307	Subsequent office visit	39.89
33308	Subsequent hospital visit	23.51
33309	Subsequent home visit	41.97
33305	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time call placed.*	93.00

The following fee items are hereby added under the heading Miscellaneous, effective July 1, 2007:

33370	Dilation of oesophagus	55.76	3
33371	- repeat within one month	33.67	3

Colonoscopy with flexible colonoscope:

S33373	- biopsy	229.07	2
33374	- removal polyp	342.47	2
33393	Percutaneous endoscopically placed feeding tube (PEG) – procedural fee	159.28	3
33394	Assistant fee for PEG procedure	109.56	

Note: *33393, 33394 may be billed by any qualified physician.*

Geriatric Medicine

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective August 1, 2007:

New Fee Items:

The following new listings, descriptions and notes are effective as indicated:

The following note is added subsequent to the Sectional heading:

These listings cannot be correctly interpreted without reference to the Preamble, please refer to the appropriate section in the Medical Services Commission Payment Schedule available on the MSP web site at: http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html

Referred Cases

33410	**Consultation**: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	137.05
33412	**Repeat or limited consultation**: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	65.80

Geriatric Assessment and Reassessment

33401	Comprehensive geriatric assessment – limited to patients aged 75 years and over	217.85
33402	Geriatric reassessment subsequent to comprehensive assessment – limited to patients aged 75 years and over	59.62

Notes:

i) 33401 and 33402 are payable only to qualifiedqualified geriatricians

ii) 33401 and 33402 are applicable to the assessment of geriatric patients who have multiple physical, mental and/or social problems; who often require a collateral history from physicians, other health care givers and family; and for whom community services may be required. Includes diagnostic interview and examination, including cognitive, functional and social assessment, review of X-ray, laboratory and other relevant records, treatment recommendations and a written report.

33414	Prolonged visit for counselling (maximum, four per year)	44.80

Note: *See Preamble, Clause B.4.c.*

Group counselling for groups of two or more patients:

33413	- first full hour	91.75
33415	- second hour, per 1/2 hour or major portion thereof	45.85

Continuing care by consultant:

33406	Directive care	38.19
33407	Subsequent office visit	39.89
33408	Subsequent hospital visit	23.51
33409	Subsequent home visit	41.97
33405	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time call placed.*	93.00

Hematology and Oncology

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective August 1, 2007:

New Fee Items:

The following new listings, descriptions and notes are effective as indicated:
The following note is added subsequent to the Sectional heading:

These listings cannot be correctly interpreted without reference to the Preamble, please refer to the appropriate section in the Medical Services Commission Payment Schedule available on the MSP web site at: http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html

Referred Cases

33510	**Consultation**: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	137.05
33512	**Repeat or limited consultation**: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	65.80
33514	Prolonged visit for counselling (maximum, four per year) ***Note:*** *See Preamble, Clause B.4.c.*	44.80

Group counselling for groups of two or more patients:

33513	- first full hour	91.75
33515	- second hour, per 1/2 hour or major portion thereof	45.85

Continuing care by consultant:

33506	Directive care	38.19
33507	Subsequent office visit	39.89
33508	Subsequent hospital visit	23.51
33509	Subsequent home visit	41.97
33505	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time call placed.*	93.00

Examination by Certified Hematologist and Oncologist

33538	Plasmapheresis – therapeutic	112.59

Chemotherapy

a) *Where a patient has been administered high intensity cancer chemotherapy, the fees for limited cancer chemotherapy are not payable within the interim of 28 days.*

b) *Hospital visits are not payable on the same day.*

c) *Visit fees are payable on subsequent days, when rendered.*

d) *A consultation, when rendered, is payable in addition to fee item 33581, high intensity cancer chemotherapy, in situations where it is important that chemotherapy be administered immediately, e.g.: for out of town patients. A letter of explanation is required when both services are performed on the same day.*

e) *The administering of chemotherapy via intrathecal and intrabladder methods is payable under the chemotherapy listings. Other methods of administration, such as oral and rectal, are not payable under these listings.*

33581 High intensity cancer chemotherapy: to include admission history and physical examination, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line, and administration of a parenteral chemotherapeutic program which must be given on an in-patient basis 146.10

Note: *This service is not payable more frequently than once every 28 days. The following treatments fall into this category:*
a) chemotherapy for acute leukemia;
b) chemotherapy utilizing cisplatinum given in a dose exceeding 50 mg/m2 per treatment;
c) chemotherapy utilizing isophosphamide in combination with bladder protector Mesna;
d) chemotherapy using DTIC in a dose exceeding 100 mg/m2;
e) chemotherapy utilizing methotrexate in dose exceeding 1 g/m2 (and combined with the folinic acid rescue regimen);
f) chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol.)

33582 **Major Cancer Chemotherapy**:
To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line and administration of multiple parenteral chemotherapeutic agents 85.69

Note*: This service is not payable more than once every 7 days.*

33583 **Limited Cancer Chemotherapy**:
To include the administration of single parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line 48.97

Note: *This item is not payable more than once every 7 days. Neither is it to be billed for routine IV push administration of 5-flourouracil as a single agent.*

Infectious Diseases

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective August 1, 2007:

New Fee Items:

The following new listings, descriptions and notes are effective as indicated - the following note is added subsequent to the Sectional heading:

These listings cannot be correctly interpreted without reference to the Preamble, please refer to the appropriate section in the Medical Services Commission Payment Schedule available on the MSP web site at: http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html

Referred Cases

33610	**Consultation**: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	137.05
33612	**Repeat or limited consultation**: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	65.80
33614	Prolonged visit for counselling (maximum, four per year) ***Note:*** *See Preamble, Clause B.4.c.*	44.80

Group counselling for groups of two or <u>more patients</u>:

33613	- first full hour	91.75
33615	- second hour, per 1/2 hour or major portion thereof	45.85

<u>Continuing care by consultant:</u>

33606	Directive care	38.19
33607	Subsequent office visit	39.89
33608	Subsequent hospital visit	23.51
33609	Subsequent home visit	41.97
33605	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time call placed.*	93.00

New Fee Items

The following new listings are to be added under the "Referred Cases" heading, effectively immediately:

<u>Telehealth Service with Direct Interactive Video Link with the Patient</u>

T33630	Telehealth Consultation: Shall include a detailed history and physical examination, review of previous medical records, discussion with family, friends or witnesses, evaluation of appropriate laboratory, X-ray and ECG findings and report of opinions and recommendations in writing to the referred physician *Note: Restricted to FRCP Infectious Disease Physicians.*	$137.05
T33632	Telehealth Repeat or Limited Consultation: To apply where a consultation is repeated for the same condition within six months of the last visit by the consultant or where in the judgement of the consultant the consultative service does not warrant a full consultative fee	$65.80

T33636	Telehealth directive care	$38.19
T33637	Telehealth subsequent office visit	$39.89
T33638	Telehealth subsequent hospital visit	$23.51

Nephrology

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective August 1, 2007:

New Fee Items:

The following new listings, descriptions and notes are effective as indicated - the following note is added subsequent to the Sectional heading:

These listings cannot be correctly interpreted without reference to the Preamble, please refer to the appropriate section in the Medical Services Commission Payment Schedule available on the MSP web site at: http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html

Referred Cases

33710	**Consultation**: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	137.05
33712	**Repeat or limited consultation**: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	65.80
33714	Prolonged visit for counselling (maximum, four per year) ***Note:*** *See Preamble, Clause B.4.c.*	44.80

Group counselling for groups of two or <u>more patients</u>:

33713	- first full hour	91.75
33715	- second hour, per 1/2 hour or major portion thereof	45.85

<u>Continuing care by consultant:</u>

33706	Directive care	38.19
33707	Subsequent office visit	39.89
33708	Subsequent hospital visit	23.51
33709	Subsequent home visit	41.97
33705	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time call placed.*	93.00

Dialysis Fees

(A) Acute renal failure

a) <u>Haemodialysis:</u>

33750	Blood dialysis – physician in charge	456.44
33751	Repeat blood dialysis - physician in charge ***Notes:*** *iii) Maximum number of repeat dialysis on one patient is four. Thereafter bill as chronic renal failure, under fee item 33758.* *iv) When Items 33750 or 33751 are charged, there should be no charge under items 33710, 33708, or 00081.*	171.53

33752 Blood dialysis - fee for cut down by surgeon to be charged in addition to items 33750 or 33751 ..... 115.39

b) Peritoneal dialyisis:

33755 Dialysis (initial), to include consultation and two weeks care 341.49

33756 Reinsertion of peritoneal catheter after 10 days from initial insertion 44.86

Note:

Item 00081 not to be charged in addition to item 33755. Where an initial peritoneal dialysis is performed and for various reasons, haemodialysis initiated within next 48 hours, the subsequent service should be charged under item 33758 plus item 33756 for the insertion of catheter.

(B) Chronic renal failure

a) Haemodialysis:

33758 Performance of haemodialysis – fee to include supervision of the procedure, history, physical examination, appropriate adjustment of solutions, and other problems during dialysis, for each dialysis 44.86

Note:

Other medical situations which may arise such as septicaemia, etc., to be covered by item 00081 and always to be accompanied by an explanation when billing the Plan.

b) Peritoneal Dialysis:

33723 Performance of initial peritoneal dialysis to include consultation and two weeks' care 341.49

33759 Performance of each peritoneal dialysis thereafter, - fee to include supervision of procedure, history, physical examination, appropriate adjustments of solutions, and any other problem that may arise during dialysis 44.86

Notes:

iii) Other situations requiring medical care such as bacteriaemias, etc., to be covered by item 00081 in the Payment Schedule and always to be accompanied by an explanation.

iv) If a period greater than three months elapses since last dialysis, then charge as initial dialysis 33755.

Home Dialysis

33761 Supervision of home dialysis - per week 54.23

Note:

This fee item covers all services per week necessary for home or limited care dialysis and includes consultations and visits of all types. Should a patient take ill with a condition totally unrelated to renal care or require hospitalization for any reason, then other appropriate fee items may be billed in lieu of fee item 33761.

Miscellaneous

33790 Care of renal transplant patient, including immediate preparation and fourteen days post-operative care 1015.65

Occupational Medicine

Additions:

The following new listings, descriptions and notes are effective as indicated on July 1, 2007. In addition, the following note is added subsequent to the Sectional heading:

These listings cannot be correctly interpreted without reference to the Preamble, please refer to the appropriate section in the Medical Services Commission Payment Schedule available on the MSP web site at: http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html

Referred Cases

33910	**Consultation**: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	144.34
33912	**Repeat or limited consultation**: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	72.62
	Continuing care by consultant:	
33907	Subsequent office visit	44.99

Respirology

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective February 29, 2008:

Deleted Fee Items

The following fee items are hereby deleted:

	Expired gas analysis to measure mixed venous CO_2:	
S00962	- professional fee	3.13
S00963	- technical fee	15.64
	Lung compliance with pressure volume plot:	
S00966	- professional fee	45.09
S00967	- technical fee	35.71

Rheumatology

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective April 1, 2006:

Amendment

The payment rates for the following Rheumatology items are hereby amended as indicated.

These modifications will be monitored for a period of one year, effective September 1, 2007 to August 31, 2008. After this time, they will be adjusted retroactively and prospectively to ensure that the actual monetary impact equals the expected impact.

T31012 Repeat or Limited Consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgement of the consultant, the consultative services do not warrant a full consultative fee 97.00

Continuing care by consultant

T31007 Subsequent office visit 60.09

Amendment

The cancellation dates of the following provisional items have been extended. This Minute will expire on January 31, 2009 or when replaced by a subsequent Minute, whichever occurs first:

P31110 Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 144.34

P31112 Telehealth Repeat or Limited Consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant, the consultative services do not warrant a full consultative fee 72.62

P31106 Telehealth directive care 40.00

P31107 Telehealth subsequent office visit 44.99

P31108 Telehealth subsequent hospital visit 29.10

Obstetrics and Gynecology

Amendment

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective October 19, 2007.

The following listing is hereby amended by adding the indicated note:

T04039 Management of complicated labour obstetrician

Notes:

v. Payable only for the following conditions:

Maternal Conditions:

h) Maternal obesity – BMI > 40

Orthopaedics

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective April 1, 2006:

Amendment

These modifications will be monitored for a period of one year, effective September 1, 2007 to August 31, 2008. After this time, they will be adjusted retroactively and prospectively to ensure that the actual monetary impact equals the expected impact.

51010 Consultation: (in office or hospital) To include a history and physical examination, review of X-ray and laboratory findings, and a written report 92.60

51007 Orthopaedic office visit 32.68

Pediatrics

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective as indicated:

New Fee Items:

The following items are funded through the Recruitment and Retention funding and have been approved on a provisional basis, effective November 1, 2007. These modifications will be monitored for a period of 18 months. After this time, they will be adjusted retroactively and prospectively to ensure that the actual monetary impact equals the expected impact. This Minute will expire on April 30, 2009 or when replaced by a subsequent Minute, whichever occurs first:

1) The following fee items will be listed in the Referred Cases section of the Pediatric Schedule:

P00550 Extended Consultation – exceeding 53 minutes (actual time spent with patient): To consist of an examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....208.25

Notes:

i) Applicable to patients with chronic and complex medical needs.
ii) Not payable in addition to 00510, 00511, 00512 or 00551.
iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.

P00551 Extended Consultation – exceeding 68 minutes (actual time spent with patient): To consist of an examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....258.25

Notes:

i) Applicable to patients with chronic and complex medical needs.
ii) Not payable in addition to 00510, 00511, 00512 or 00550.
iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.

P00553 Extended subsequent office visit – exceeding 23 minutes (actual time spent with patient): 88.86

Notes:

i) Applicable to patients with chronic and complex medical needs.
ii) Not payable in addition to 00507 or 00554.
iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.

P00554 Extended subsequent office visit – exceeding 38 minutes (actual time spent with patient): 128.86

Notes:

i) Applicable to patients with chronic and complex medical needs.
ii) Not payable in addition to 00507 or 00553.
iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.

2) The following fee items will be listed under the Special Procedures heading in the Pediatric Schedule:

PSY00541 Pediatric urethral catheterization in child under 5 years – isolated procedure..... 18.00

Notes:

i) Procedure not payable if delegated to a non-physician.
ii) Not payable with critical care listings or diagnostic urological procedures (e.g.: voiding cystourethrogram.)
iii) Restricted to Pediatricians.

3) The following fee items will be listed under the Special Procedures heading, under the new sub-heading Chemotherapy in the Pediatric Schedule:

Chemotherapy

a) Where a patient has been administered high intensity cancer chemotherapy, the fees for limited cancer chemotherapy are not payable within the interim of 28 days.
b) Hospital visits are not payable on the same day.
c) Visit fees are payable on subsequent days, when rendered.
d) A consultation, when rendered, is payable in addition to fee item P00578, high intensity cancer chemotherapy, in situations where it is important that chemotherapy be administered immediately, e.g.: for out of town patients. A letter of explanation is required when both services are performed on the same day.
e) The administering of chemotherapy via intrathecal and intrabladder methods is payable under the chemotherapy listings. Other methods of administration, such as oral and rectal, are not payable under these listings.

P00578 **<u>High Intensity Cancer Chemotherapy for patients 16 years of age and under:</u>**

To include admission history and physical examination, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line, and administration of a parenteral chemotherapeutic program which must be given on an in-patient basis 220.00

Notes: *This service is not payable more frequently than once every 28 days. The following treatments fall into this category:*

a) chemotherapy for acute leukemia;
b) chemotherapy utilizing cisplatinum given in a dose exceeding 50 mg/m2 per treatment;
c) chemotherapy utilizing isophosphamide in combination with bladder protector Mesna;
d) chemotherapy using DTIC in a dose exceeding 100 mg/m2;
e) chemotherapy utilizing methotrexate in dose exceeding 1 g/m2 (and combined with the folinic acid rescue regimen);
f) chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol.)

P00579 **Major Intensity Cancer Chemotherapy for patients 16 years of age and under**:
To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line and administration of multiple parenteral chemotherapeutic agents 170.00
***Note**: This service is not payable more frequently than once every 7 days.*

P00580 **Limited Intensity Cancer Chemotherapy for patients 16 years of age and under**:
To include the administration of single parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line 100.00
***Note:** This service is not payable more frequently than once every 7 days. Neither is it to be billed for routine IV push administration of 5-flourouracil as a single agent.*

4) The following fee items will be listed under the Diagnostic Procedures heading in the Pediatric Schedule:

PSY00570 Lumbar puncture in a patient 12 years of age and younger..... ..... 75.00
***Note:** Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.*

PS00571 Pediatric esophagogastroduodenoscopy in a patient 16 years of age and under..... 180.00 3
***Note:** Restricted to Pediatricians.*

PS00572 Pediatric colonoscopy with flexible colonoscope – patients 16 years of age and under 330.00 2
Notes:
i) Includes biopsies, removal of polyps, collection of specimens by brushing or washing, control of bleeding, removal or foreign body, if required.
ii) Restricted to Pediatricians.

5) The following fee items will be listed under a new heading "Cardiovascular Procedures" in the Pediatric Schedule:

PS50520 Pediatric right heart catheterization – patients 0 – 6 years of age 324.52 4
***Note:** Restricted to BC Children's Hospital.*

PS50521 Pediatric right heart catheterization – patients 7 – 16 years of age 243.39 4
***Note:** Restricted to BC Children's Hospital.*

PS50527 Pediatric retrograde left heart catheterization, extra – patients 0 – 6 years of age 259.56 4
***Note:** Restricted to BC Children's Hospital.*

PS50528 Pediatric retrograde left heart catheterization, extra – patients 7 – 16 years of age 194.67 4
***Note:** Restricted to BC Children's Hospital.*

PS50530 Pediatric trans-septal left heart catheterization – patients 0 – 6 years of age 349.76 4
***Note:** Restricted to BC Children's Hospital.*

PS50531 Pediatric trans-septal left heart catheterization – patients 7 – 16 years of age 262.32 4
***Note**: Restricted to BC Children's Hospital.*

PS50539 Pediatric percutaneous transluminal coronary angioplasty – patients 0- 6 years of age 738.78 4
Note: *Restricted to BC Children's Hospital.*

PS50540 Pediatric percutaneous transluminal coronary angioplasty – patients 7- 16 years of age 554.09 4
Note: *Restricted to BC Children's Hospital.*

PS50541 Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 0 – 6 years of age 389.48 4
Note: *Restricted to BC Children's Hospital.*

PS50542 Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 7– 16 years of age 292.11 4
Note: *Restricted to BC Children's Hospital.*

PS50545 Pediatric therapeutic radiological embolization – patients 0 – 6 years of age 677.44 3
Note: *Restricted to BC Children's Hospital.*

PS50546 Pediatric therapeutic radiological embolization – patients 7 – 16 years of age 508.08 3
Note: *Restricted to BC Children's Hospital.*

P50550 Percutaneous cardiac stenting in pediatric patients (0 – 18 years of age) - composite fee (operation only) 950.00 7
Notes:
i) Applicable to placement of stents in vena cava, pulmonary or coronary arteries and veins and aorta.
ii) Includes all necessary diagnostic imaging, right and left heart catheterization, all necessary angiograms and/or angioplasty, coronary or elsewhere and stent implantation to include any declotting or treatment of underlying cause of access failure.
iii) Not payable with fee items 00898 and 00871. This composite also includes the taking of blood pressure (intra-arterial or intravenous), calculation of pressure gradients during the procedure and any pharmacological study or infusion of therapeutic substance.
iv) Payable to Pediatricians only.
v) Medically necessary assistance payable under cardiac assist fee items 00845 and 00846.

P50551 - Additional stents – extra 200.00
Notes:
i) Must be inserted into a differently named, non-contiguous vessel (provide information in note record).
ii) Maximum payable is 2 additional stents.

P50555 Percutaneous transcatheter cardiac occluder device closure of ASD in pediatric patients (0 – 18 years of age) – composite fee (operation only) 950.00 7
Notes:
i) Includes all necessary diagnostic imaging, right and left heart catheterization, all necessary angiograms and/or angioplasty, coronary or elsewhere and stent implementation to include any declotting or treatment of underlying casue of access failure.
ii) Not payable with fee item 00871. This composite fee also includes the taking of blood pressure (intra-arterial or intravenous), calculation of pressure gradients during the procedure and any pharmacological study or infusion of therapeutic substance.
iii) Payable to Pediatricians only.
iv) Medically necessary assistance payable under cardiac assist fee items 00845 and 00846.

Amendment

The following listing is amended by changing the fee description, increasing the payment rate and adding a note as indicated:

SY00750 Lumbar puncture in a patient 13 years of age and over 50.00 2
Note: *Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.*

Amendment

The cancellation dates of the following provisional items have been extended. This Minute will expire on January 31, 2009 or when replaced by a subsequent Minute, whichever occurs first:

P50510 Telehealth Consultation: To consist of an examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 169.74

P50511 Telehealth Consultation for complex behavioural, developmental or psychiatric condition in a child: To consist of a physical and neurological examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 343.92
Notes:
i) Not to be billed when no change in condition from previous assessment.
ii) Minimum time requirement for service is 1.5 hours.
iii) Developmental delays include, but are not limited to: non-verbal learning disability, developmental reading disability, developmental coordination disability, developmental writing disability, dyscalculia, autistic spectrum disorders, fetal alcohol syndrome, mental retardation and other cognitive defects.
iv) Includes collection of data from collateral sources and formal screening, as appropriate.

P50512 Telehealth repeat or limited consultation: Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee 82.32

P50514 Telehealth prolonged visit for counselling 63.67
Note*: The Plan will pay up to four such visits per year (see Clause B.4.c. of the Preamble).*

P50506 Telehealth directive care 41.00

P50507 Telehealth subsequent office visit 52.41

P50508 Telehealth subsequent hospital visit 41.44

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective April 1, 2008:

Amendment:

The cancellation date of the following provisional item has been extended. This Minute will expire on September 30, 2009 or when replaced by a subsequent Minute, whichever occurs first:

P00545 Pediatric Case Conference – a formal, scheduled session/meeting, initiated at the request of the pediatrician, to discuss/plan medical management of patients with serious and complex pediatric problems, which may include family physicians or hospital staff (if an in-patient) or a relative and must include at least one professional or community agency representative.
– per ¼ hour $42.63

Notes:

i) Patient must be 18 years of age or younger.

ii) For services related to:
- *a. psychiatric disorders*
- *b. developmental disorders*
- *c. major chronic disease*
- *d. pre-transplant (concerning donor/recipient assessment)*
- *e. end of life*
- *f. multiple medical handicaps*

iii) Maximum of one hour may be claimed per patient per day.

iv) Not to exceed a maximum of two hours per patient per year.

v) The case conference must last at least 30 minutes to submit a claim.

vi) The results of the case conference must be recorded in the patient's chart along with the start and end times of the conference, as well as the names and job titles of the other participants at the meeting.

vii) This fee is not payable to physicians who are employed or who are under contract to a facility, agency or program (ie: Ministry of Children and Families' FAS, autism and child abuse or neglect assessments, HEAL, health authorities) who otherwise would have attended the conference as a requirement of their employment with the facility, agency or program.

viii) This fee is payable when the care conference occurs in person (ie: not payable when service provided by telephone or telehealth).

ix) A visit or consult may be payable for the same patient on the same day as a case conference, provided the two items are consecutive, not concurrent, and start and end times are provided for both. A note record must be submitted for consults and patient management conferences occurring on the same day.

x) It may not be claimed unless the pediatrician has seen the patient within the previous 180 days.

xi) Not payable within 3 months of fee item 00511 without a note record explaining the medical necessity.

xii) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods and services are to be claimed under the PHN of each patient for the specific time period.

xiii) Start and end times must be included in time fields.

Psychiatry

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective February 01, 2007:

Amendment:

Full Telehealth Consultations:

P60610	Telehealth Individual full consultation: Diagnostic interview or examination, including history, mental status exam and treatment recommendation, with written report	185.95

New Fee Items:

The following new listings and descriptions are added under the heading Group Psychotherapy, effective August 1, 2007:

	Fee per patient, per ½ hour:	
00671	Eleven patients	11.80
00672	Twelve patients	11.10
00673	Thirteen patients	10.30
00674	Fourteen patients	10.10
00675	Fifteen patients	9.70
00676	Sixteen patients	9.40
00677	Seventeen patients	9.00
00678	Eighteen patients	8.80
00679	Nineteen patients	8.50
00680	Twenty patients	8.30
00681	Greater than 20 patients (per patient)	8.00

The General Notes pertaining to Group Psychotherapy are hereby modified as indicated:

Notes:

i) A separate claim should be submitted for each patient.

ii) Where two co-therapists are involved in a group of eight (8) or more patients, the group should be divided for claims purposes, with each co-therapist claiming the appropriate rate per patient for the reduced group size. Each claim should indicate "co-therapy" and also identify the other co-therapist.

*iii) Where a group psychotherapy session extends beyond two hours or involves more than **twenty** patients, a written explanation of need is required by thePlan.*

Amendment

The cancellation dates of the following provisional items have been extended. This Minute will expire on January 31, 2009 or when replaced by a subsequent Minute, whichever occurs first:

Full Telehealth Consultations:

P60610	Telehealth Individual full consultation: Diagnostic interview or examination, including history, mental status exam and treatment recommendation, with written report	185.95
P60613	Telehealth Geriatric consultation (patients 75 years or older)	256.46

P60622 Telehealth consultation – Emotionally disturbed child:
Diagnostic interview or examination, including mental status and treatment recommendation, assessment of parents, guardian, or other relatives and written report.....320.65

Repeat or Limited Telehealth Consultations:

Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.

P60625 Telehealth – Individual consultation.....93.91

P60614 Telehealth – Geriatric consultation.....128.21

P60626 Telehealth – Emotionally disturbed child.....160.33

Telehealth Psychiatric Treatment:

P60607 Telehealth office visit to include services such as chemotherapy management and/or minimal psychotherapy.....39.75

P60608 Telehealth hospital in-patient visit.....46.62

Individual Telehealth Psychiatric Treatment:

P60630 - per 1/2 hour.....79.46

P60631 - per 3/4 hour.....110.74

P60632 - per 1 hour.....141.81

Family/Conjoint Telehealth Therapy – (two or more family members):

P60633 - per 1/2 hour.....84.68

P60635 - per 3/4 hour.....118.01

P60636 - per 1 hour.....151.19

Miscellaneous:

P60624 Evaluation interview with family member without presence of patient - per 1/2 hour session.....72.99

P60645 Patient Management Conference - meeting by specific appointment to discuss/plan patient management with third parties, which may include referring physicians or hospital staff (if an inpatient) or relatives and must include at least one professional or community agency representative - per 1/4 hour.....39.75

Notes:

i) Not to exceed a maximum of two hours per patient per psychiatrist, per calendar year.

ii) A written record of the meeting must by maintained and/or a report generated by the psychiatrist.

iii) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.

Physical Medicine and Rehabilitation

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective April 1, 2006:

Amendment

The payment rates for the following Physical Medicine and Rehabilitation items are hereby amended as indicated.

These modifications will be monitored for a period of one year, effective September 1, 2007 to August 31, 2008. After this time, they will be adjusted retroactively and prospectively to ensure that the actual monetary impact equals the expected impact.

01710	Formal consultation: To consist of examination, review of history, laboratory, X-ray findings, functional, social, and vocational appraisal, and additional visits necessary to render a written report	184.30
01712	Repeat or limited consultation: Where a formal consultation for the same illness is repeated at an interval within six months of the last visit by the consultant	80.33
01714	Prolonged visit for counselling	72.30
	Group counselling for groups of two or more patients:	
01713	First full hour	130.25
01715	Second hour, per 1/2 hour (or major portion thereof)	65.09
	Continuing care by consultant:	
01706	Directive care	63.17
01707	Office visit	76.91
01708	Hospital visit	40.95
01709	Home visit	62.01
01705	Emergency visit when specially called	96.40
	Miscellaneous:	
01721	Family rehabilitation conference where a certified specialist in Physical Medicine and Rehabilitation is involved with two or more members of the family - per 1/2 hour or greater portion thereof, to a maximum of two hours for any one rehabilitative case	81.89
S00922	Electrodiagnostic component of the decamethoniumedrophonium test for myasthenia gravis, inclusive of tetanic stimulation tests	51.72

Plastic Surgery

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective immediately:

C06159	TRAM Flap reconstruction of mastectomy defect	1,000.00	5

Notes:

i) Includes preparation of site to be grafted, harvesting and insertion of the graft, closure of donor defect, with or without mesh.

ii) Reconstruction of both breasts (bilateral) with <u>two</u> pedicled TRAM flaps is payable at 150%.

61152	Abdominal panniculectomy – where medically indicated, secondary to chronic subpanus intertrigo, which has been unresponsive to a reasonable period of medical treatment ***Note:*** *To include umbilicoplasty where medically indicated.*	292.68	4
61166	Mastopexy, balancing unilateral (isolated procedure)	313.79	3
61167	Mastopexy, balancing – when performed at same time as contralateral breast surgery	235.34	3
61223	ORIF of phalangeal (middle or proximal) or metacarpal fracture ***Note:*** *Multiple fractures paid in accourdance with Preamble B. 10. a.*	261.00	2
61222	CRIF of phalangeal (middle or proximal) or metacarpal fracture	191.35	2

The following modification to the Payment Schedule has been approved, effective immediately:

Amendment

61166 Mastopexy, balancing unilateral (isolated procedure)

The cancellation dates of the following provisional items have been extended. This Minute will expire on January 31, 2009 or when replaced by a subsequent Minute, whichever occurs first:

P66010	Telehealth Major consultation: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report	64.73
P66012	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six (6) months of last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	35.58
P66007	Telehealth subsequent office visit	21.45
P66008	Telehealth subsequent hospital visit	18.28

General Surgery

Amendment:

Effective April 1, 2006 the payment rates for the following General Surgery items are hereby amended as indicated.

These modifications will be monitored for a period of one year, effective September 1, 2007 to August 31, 2008. After this time, they will be adjusted retroactively and prospectively to ensure that the actual monetary impact equals the expected impact.

Intestines

	Incision	
07634	Enterotomy or colotomy (single) – for exploration, biopsy, or foreign body removal	500.51
07635	Multiple colotomy, with operative sigmoidoscopy	657.12
07651	Reduction of volvulus, intussusception, internal hernia, by laparotomy	540.43

Excision

07643	Enteroenterostomy	500.51
07570	Colo-colostomy or entero-colostomy	824.47
72622	Limited resection of colon – open	809.12
C72623	- laparoscopic	809.12
72624	Hemicolectomy; right – open	849.03
C72625	- laparoscopic	849.03
72626	Hemicolectomy; left – open	901.10
C72631	- laparoscopic	901.10
72632	Sigmoid resection – open	938.08
C72633	- laparoscopic	938.08
72634	- with end colostomy and closure of distal segment or mucous fistula (Hartmann type procedure)	886.36
72635	Anterior resection of rectosigmoid for carcinoma (low pelvic anastomosis; coloproctostomy) with or without protective stoma	1,082.42
72636	Proctectomy; abdominal and transanal approach; coloanal anastomosis (with or without protective colostomy) – synchronous abdominal portion	1,156.01
72637	- synchronous perineal portion	386.91
C07569	Colectomy and hemiproctectomy	1,117.76
C07640	Colectomy – total, abdominal, (without proctectomy)	1,157.64
07567	Proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J) with or without loop ileostomy	1,590.59
07566	Rectal mucosectomy and ileoanal anastomosis	767.92
C07641	Total proctocolectomy – with perineal excision of rectum and ileostomy - single surgeon	1,690.22
07589	- synchronous – abdominal portion	1,352.62
07590	- synchronous - perineal portion	386.91
07565	Take-down of pelvic pouch, to include ileostomy	849.03
72640	Partial right colectomy (caecum) with removal of terminal ileum and ileocolostomy	809.79
72641	Caecostomy, tube for decompression (extra)	310.14
	Revision of colostomy, ileostomy:	
07648	- simple incision or scar, etc	230.62
07649	- radical; reconstruction with bowel resection	431.09
72644	- with repair of paracolostomy hernia requiring laparotomy	578.81
07645	Colostomy or ileostomy – loop	420.45
07588	- end	484.41
	Closure of loop enterostomy, large or small intestine:	
07646	- without resection	386.91
07647	- with resection and anastomosis	578.81
72651	Reconstruction Hartmann procedure with or without protective colostomy - open	849.03
C72652	- laparoscopic	849.03
	Closure of fistula; enterovesical, colovesical or colovaginal:	
72653	-without intestinal and/or bladder resection	809.79
72654	- with bowel resection (extra to 72653)	347.47
07455	Emergency resection of obstructed colon, with lavage and anastomosis	1,030.67
07658	Exteriorization of large bowel lesion (carcinoma, perforation, etc.)	618.76

Rectum

	Incision	
07660	Transrectal drainage of pelvic abscess	230.46

	Excision	
07665	Biopsy of anorectal wall, anal approach (e.g.: congenital megacolon)	155.05
C07662	Abdomino-perineal resection – single surgeon	1,384.71
07663	-synchronous abdominal portion	1,156.01
07664	-synchronous perineal portion	386.91
	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull through procedure and anastomosis (e.g.: Swenson, Duhamel, or Soave type operation):	
72662	- synchronous abdominal	1,325.83
72663	- synchronous perineal	386.91
C72664	- with subtotal or total colectomy, with multiple biopsies	1,690.22
72665	Proctectomy, partial, without anastomosis, perineal approach	515.34
72666	Excision of rectal procidentia, with anastomosis; perineal approach – Altmeir	695.52
72667	Division of stricture of rectum (includes endoscopy) – operation only	184.04
07580	Excision of rectal tumour by posterior parasacral, transacral or transcoccygeal approach (Kraske)	662.56
	Excision of rectal tumour transanal approach to include operative sigmoidoscopy:	
72669	- 0 to 2.5 cm	159.01
72670	- 2.6 to 5 cm (operation only)	213.51
72671	- greater than 5 cm (operation only)	441.71
72672	Electrodesiccation or fulguration of malignant tumour of rectum, transanal – includes endoscopy	159.01
	Repair	
T07672	Complete rectal prolapse – abdominal or perineal approach	717.55
	Rectum – Endoscopy	
07460	Sigmoidoscopy – with decompression of volvulus	224.43
07461	Sigmoidoscopy, flexible - with removal of foreign body	110.43
07462	- with control of bleeding, any method	147.22
07463	- with decompression of volvulus, any method	123.70
07464	– with removal of polyp(s) (operation only)	257.78
07465	– with ablation of tumour(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	174.33
	AnusRepair	
07690	Anoplasty for imperforate anus	618.76
07452	Repair of extra-peritoneal rectum, with or without colostomy	988.74
07689	Anal dilation under general anesthetic	93.81
	Incision	
07691	Anus imperforate – simple incision	45.52
07679	Incision and drainage of ischiorectal, intramural, intramuscular or submucosal abscess, under anesthesia	136.79
07678	Incision and drainage, perianal abscess – superficial	93.90
	Excision	
07687	Anal fissure, excision under local anesthetic..	93.90

Papillectomy or excision of anal tag or polyp:

T71689	Hemorrhoid(s); office procedure (e.g.: band ligation) to include proctoscopy	82.75
T71690	Hemorrhoid(s); office procedure – infrared photocoagulation to include proctoscopy	82.75
07683	Haemorrhoidectomy with or without sigmoidoscopy	275.28

Fistula-in-ano (fistulectomy or fistulotomy):

07675	- subcutaneous or submucous	155.05
07676	- submuscular	346.83
07677	- multiple or horseshoe, with or without placement of seton	463.67
07666	Fistula-in-ano; second stage; division of sphincter after placement of seton	160.76
71700	Closure of congenital anal fistula with rectal advancement flap	662.56

Trauma

Hepatorrhaphy; suture of liver wound or injury:

07450	Exteriorization of colonic injury	618.76
07448	Repair of colonic injury with or without colostomy	988.74
07449	Resection of colonic injury	988.74

Paediatric Procedures

07466	Anal stricture; plastic repair; child	462.64
C07692	Repair major ano-rectal anomalies – with concurrent uro-genital malformations via sacral approach	927.34
C07697	Excision sacrococcygeal teratoma	1,082.42
07700	Total correction cloacal anomalies; primary surgeon	2,208.53
07702	Fee for second surgeon participating in total correction of cloacal anamolies	404.91

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective as indicated:

The following fee items are hereby deleted, effective October 31, 2007:

Extensive debridement of skin, soft tissue and/or muscle and/or bone for management of necrotizing infections or severe trauma: (includes 14 days post-operative care):

70151	- trunk	393.05	3
70152	- limb	393.05	3

New Fee Items:

The following new fee items are hereby added under the new heading Debridement of Soft Tissues for Necrotizing Infections or Severe Trauma, effective November 1, 2007. The implementation date for these modifications will be November 6, 2007.

70155	Debridement of skin and subcutaneous tissue restricted to genitalia and perineum for necrotizing infection (Fournier's Gangrene) (stand alone procedure)	393.05	5
70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	225.00	3
70159	Debridement of skin and subcutaneous tissue; for each subsequent 5% of body surface area or major portion thereof	112.50	

70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	250.00	4
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each subsequent 5% of body surface area or major portion thereof	125.00	
70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	275.00	4
70166	Debridement of skin, fascia, muscle and bone; for each subsequent 5% of body surface area or major portion thereof	137.50	
70168	Active wound management during acute phase after debridement of soft tissues for necrotizing infection or severe trauma – per 5% of body surface area	75.00	

Notes:

i) Payable when rendered at the bedside but only when performed by a medical practitioner.

ii) Requires wound assessment and dressing change and may include VAC application.

iii) Applicable with or without anesthesia.

70169	Active wound management during acute phase after debridement of soft tissue for necrotizing infection or severe trauma – per 5% of body surface area	120.00	4

Notes:

i) Payable only when performed by a medical practitioner in the operating room under general anesthesia or conscious sedation.

ii) Requires wound assessment and dressing change and may include VAC application.

iii) Debridement not payable in addition.

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective December 15, 2006. The implementation date for these modifications will be December 1, 2007, or earlier.

Amendments:

1. The payment rate of the following fee item is hereby adjusted as indicated:
2. The following notes are to be added to the indicated fee item:
3. The status is converted from a "P" (Provisional) to a "T" (Temporary):

CT07368	Laparoscopic splenectomy	737.50	6

Notes:

i) Fee items 07360 or 07434 not payable in addition.

ii) If laparoscopic procedure is converted to open, bill under 07360 at 100% and 04001 at 50%.

Vascular Surgery

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective November 1, 2007:

Amendment:

The following fee items are hereby assigned a "C" prefix:

C77210	Axillo-Femoral Bypass Graft (Synthetic) and/or Thromboendarterectomy - unilateral	
C77215	- bilateral	
C77220	Axillo-Femoral Bypass Graft (Autogenous Vein) - Unilateral	
C77230	Femoro-femoral crossover bypass graft (synthetic) and/or thromboendarterectomy	
C77235	Femoro-femoral crossover bypass graft (autogenous vein)	
C77240	Infrainguinal: Femoral bypass graft (synthetic) and/or thromboendarterectomy (common or superficial endarterectomy)	
C77245	- popliteal (endarterectomy)	
C77250	- popliteal (synthetic)	
C77255	- anterior, posterior, tibial or peroneal	
C77260	Bypass Graft (Autogenous Vein) - Femoral	
C77265	- popliteal	
C77270	- anterior, posterior, tibial or peroneal	
C77330	Repair of injury of major vessel in extremity - suture	
C77335	- graft	
C77340	Repair of injury of major vessel in trunk - suture	
C77345	- graft	

Cardiac Surgery

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective immediately:

Amendment
The anesthetic intensity and complexity level for the indicated fee item is hereby confirmed as follows:

07960	Intra-aortic balloon insertion, removal and care	630.17	8

Deletion
The following note is hereby deleted from Fee Item 07960 (*Intra-aortic balloon insertion, removal and care):*

> ***Note:*** *Anesthetic intensity/complexity level 10 applies when performed as an isolated procedure.*

Amendment:

The following fee items are hereby amended by backdating the effective date from October 20, 2006 to April 1, 2006:

P78041	Laser Lead Extraction after 30 days, first lead ***Notes:*** *i) Not payable with 07845, 00330, and 00357.* *ii) Includes any and all diagnostic imaging related to the surgery.* *iii) Claims for surgical assistance for laser lead extraction are payable under 00197.*	$1331.92	9
P78042	Laser Lead Extraction after 30 days, additional leads, to a maximum of two – extra	$500.00	9

P78043	Debridement of chest wall during laser lead extraction- extra (payable only with 78041)	$50.00	9
P78044	Wide debridement of chest wall during laser lead extraction - extra (payable only with 78041)	$100.00	9

Thoracic Surgery

Amendment

The cancellation dates of the following provisional items have been extended. This Minute will expire on January 31, 2009 or when replaced by a subsequent Minute, whichever occurs first:

P79210	Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, and a written report	114.41
P79212	Telehealth Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	51.49
P79207	Telehealth subsequent office visit	22.83
P79208	Telehealth subsequent hospital visit	19.48

Radiology

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective April 1, 2006:

Amendment

The payment rates for the following Radiology items are hereby amended as indicated.

These modifications will be monitored for a period of one year, effective September 1, 2007 to August 31, 2008. After this time, they will be adjusted retroactively and prospectively to ensure that the actual monetary impact equals the expected impact.

Diagnostic procedures utilizing radiological equipment:

S00733	Venogram, intraosseous, or intravenous – procedural fee	56.20
S00868	Percutaneous gastrostomy/:gastrojejunostomy – procedural fee	246.39

Therapeutic procedures utilizing radiological equipment:

S00978	Percutaneous nephrostomy, procedural fee	268.13
S00979	Percutaneous nephrostomy, with dilatation of tract for endoscopic urological manipulation, procedural fee	357.43
S00980	Transhepatic biliary drainage procedure (includes 00857)	378.78
S00981	Therapeutic radiological embolization	378.78
S00982	Percutaneous transluminal angioplasty	361.07
S00983	Percutaneous abdominal abscess drainage by catheter insertion	246.61
S00984	Exchange of previously inserted catheter or tract dilatation for percutaneous biliary or renal drainage	112.97

Cardio-vascular Diagnostic Procedures – procedural fees:

S00843	Selective arteriography of any abdominal branch by catheter, extra:- for first branch (each additional branch 50% extra)	89.91
S00847	Selective arteriography of any thoracic aortic branch (excluding coronaries) extra – for first branch (each additional branch 50% extra)	145.77
	Aortogram:	
S00890	- abdominal – procedural fee	103.53
S00897	- thoracic – procedural fee (extra except when part of a retrograde left heart catheterization)	148.82
	Arteriogram – procedural fee:	
S00892	- carotid percutaneous; unilateral	102.30
S00891	- carotid percutaneous; bilateral	153.83
S00893	- femoral or axillary	79.20
S00853	Superior venacavogram, by indirect means	21.61
S00854	Inferior venacavogram	103.53
S00896	Pulmonary arteriography	125.67

Laboratory Medicine

Amendment:

The provisional status ("P") is hereby removed from the following two listings. These items are effective on a temporary basis until November 30, 2009. On November 30, 2009 and after review by the British Columbia Medical Association, a recommendation may be made to remove the temporary status:

		$
T92515*	Blood Methadone ***Note:*** *Up to two specimens payable per day.*	43.73
T92510	Methadone Metabolite	6.49

The following note is hereby added to the indicated fee item:

P92513	Methadone ***Note:*** *Not billable if laboratory has capability of performing methadone metabolite screening test.*	3.34

In addition, the notes subsequent to fee item P92513 and pertaining to Drugs of Abuse Screening Assays are modified as follows:

i) A maximum of 7 screening assays per patient, per day may be billed.
ii) A request for a "drug screen" will be interpreted as a request for analysis for methadone/methadone metabolite, opiates, benzodiazepines, cocaine/cocaine metabolite and amphetamines only.

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective July 1, 2007:

Amendment:

The cancellation date of the following provisional items have been extended. This Minute will expire on December 31, 2008 or when replaced by a subsequent Minute, whichever occurs first:

P92355	Troponin	14.36
P91760***	Helicobacter pylori Carbon 13 urea breath test	34.80

P91719 Glucose- 2 hr, post-75 g 15.23
P92227 Sirolimus 41.00
P92513 Methadone 3.34

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective August 1, 2007:

Amendment

The following fee item is hereby amended by modifying the fee description and adding a Note:

93050 Cytogenetic analysis/fluorescence in situ hybridization (FISH), complex 444.69
Note:
For cytogenetic evaluation of engraftment in opposite-sex bone marrow transplants, follow-up investigations for leukemia patients with known, cancer specific chromosome abnormalities, and rare and complex investigations requiring detailed molecular probing.

New Fee Items

The cancellation date of the following provisional items has been extended. This Minute will expire on January 31, 2009 or when replaced by a subsequent Minute:

P93051 Cytogenetic analysis/fluorescence in situ hybridization, single probe 183.56
Notes:
i) For investigations in which a single molecular probe reagent is used as an adjunct to standard cytogenetic techniques for the detection or interpretation of specific chromosome abnormalities.
ii) To a maximum of three services per patient; greater than 3 services requires a note record.

P93052 Cytogenetic analysis/fluorescence in situ hybridization, subtelomeric probe 491.10
Notes:
i) For sub-microscopic evaluation of the ends of the 24 different chromosomes in patients with unexplained mental and/or physical disorders.
ii) *Restricted to Royal Columbian Hospital.*

P93053 Cytogenetic analysis/fluorescence in situ hybridization (FISH), uncultured amniotic fluid 371.18
Note:
For testing amniotic fluids using a probe set designed for rapid testing of more commonly encountered abnormalities in chromosome number.

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective November 1, 2007:

New Fee Item:

The following new fee item has been approved on a provisional basis, effective November 1, 2007. This Minute will expire on April 30, 2008 or when replaced by a subsequent Minute, whichever occurs first.

P91275*** B-type Natriuretic Peptide (BNP or NT-proBNP) $34.50
Notes:
Payable for:
(a) assessment of symptomatic patients where the diagnosis of heart failure remains in doubt after standard assessment.
(b) repeat testing not payable more than once annually unless ordered by the physician for new clinical episode suspicious for heart failure.
(c) not payable for repeat testing for monitoring therapy.

The following modification to the payment schedule has been approved, effective October 19, 2007:

New Fee Item

90068	Cyclic citrullinated peptide antibodies	$28.41

Notes:

i) Payable only once if order by Rheumatologist or General Internal Medicine Specialist.

ii) Not payable for established rheumatoid arthritis.

BRITISH COLUMBIA
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BRITISH COLUMBIA MEDICAL ASSOCIATION

COMMUNITY-BASED MENTAL HEALTH INITIATIVE
January 2008

Introduction

The current health system designed for episodic care can create a substantial burden on both patients living with mental illness and the family physicians who provide the bulk of their care. British Columbians, through the Conversation on Health process, have identified mental health and addictions as a major concern of the health system. The inability of the current system to respond to serious mental illness results in very high burden to patients and their families and, in terms of health system costs because of unnecessary emergency department, hospitalizations and re-hospitalizations. In addition, studies of regional variation in expenditure for specialist services have demonstrated that greater specialist inputs do not produce better outcomes. International and inter-jurisdictional studies have shown that populations that have better access to primary care have better health outcomes. For example, in the Downtown Eastside of Vancouver, 70% of the population living with mental illness and addictions do not have access to primary health care. The purpose of the mental health initiative is to encourage better access to primary care for people with mental illness, and to improve the quality of that care, with special attention to coordination of care planning and continuity of information and to encourage a shared care model of management where possible. The ultimate goal of these improved care processes is to improve the health outcomes of the patients in terms of both better quality of life and reduced mortality and morbidity.

Mental Health Initiative

Family physicians will identify their high-risk patients living in the community (i.e. home or assisted living) who meet the following criteria:

i) Axis I diagnosis confirmed by DSM IV criteria;
ii) Severity and Acuity level causing sufficient interference in activities of daily living that developing a management plan would be appropriate.

Additional factors that increase risk include drug or alcohol addiction, cognitive impairment, poor nutritional status, and socioeconomic factors such as homelessness. Given these factors, the approach to be encouraged is to manage the whole patient, not the disease.

The physician – or practice – will need to accept the role of being Most Responsible for the longitudinal, co-ordinated care of that patient for that calendar year

The Mental Health Planning Fee and resulting access to an increased number of billable GP management/counselling fees is intended to recognize the significant investment in time and skill such clients/patients require in General Practice. These Fee items are intended to acknowledge the vital role of the GP in supporting patients with mental illness and addictions to remain safely in their home community. Once the Mental Health Plan is developed, GPs are encouraged to collaborate with community mental health resources, in providing longitudinal mental health support for these patients across the spectrum of care needs. This networking is

complementary to, and eligible for, the Community Patient Conferencing Fee (G14016) if all other requirements are met.

The initial GP/FP service providing 'Portal' access to the mental health care management fees shall be the development of a Mental Health Care Plan for a patient with significant mental health conditions residing in their home or assisted living (excluding care facilities).

This fee requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, and use of appropriate validated assessment tools, with confirmation of diagnosis through DSM IV diagnostic criteria. It requires a face-to-face visit with the patient, with or without the patient's medical representative.

From these activities (review, assessment, planning and documentation) a Mental Health Care Plan for that patient will be developed that documents in the patient's chart:

- that there has been a detailed review of the patient's chart/history and current therapies;
- the patient's mental health status and provisional diagnosis by means of psychiatric history and mental state examination;
- the use of and results of validated assessment tools. GPSC strongly recommends that these evaluative tools, as clinically indicated, be kept in the patient's chart for immediate accessibility for subsequent review. Assessment tools such as the following are recommended, but other assessment tools that allow risk monitoring and progress of treatment are acceptable:
    - i) PHQ9, Beck Inventory, Ham-D for depression;
    - ii) MMSE for cognitive impairment;
    - iii) MDQ for bipolar illness;
    - iv) GAD-7 for anxiety;
    - v) Suicide Risk Assessment;
    - vi) Audit (Alcohol Use Disorders Identification Test) for Alcohol Misuse;

- DSM-IV Axis I confirmatory diagnostic criteria;
- a summary of the condition and a specific plan for that patient's care;
- an outline of expected outcomes;
- outlined linkages with other health care professionals (Including Community Mental Health Resources and Psychiatrists) as indicated and/or available) who will be involved in the patient's care, and their expected roles;
- an appropriate time frame for re-evaluation of the Mental Health Plan;
- that the developed plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other health professionals as indicated.

Once the Mental Health Plan has been created, the General Practitioner or practice group can access two additional supports:

1) GP Mental Health Management Fees: an additional four visit fees equivalent to the current age differential 00120 series. These fees are billable after the current four counselling visits per year (00120 fees per *MSC Payment Schedule*) have been billed.

2) GP Mental Health Telephone/Email Management Fees; access to telephone/email follow-up fees to allow flexibility in providing non-face-to-face management/follow-up for these patients. These telephone/email follow-up services may be provided by the physician or other medical professionals that are directly under the family physician or practice group's supervision (e.g. MOA or Office nurse). The telephone follow up care

fee is to be used for providing clinical management such as medication, symptom, and clinical status monitoring. It is not for simple appointment reminder or referral notification. The telephone management fee may be billed up to a maximum of five times per calendar year, for either physician-initiated or patient-initiated follow up.

The Mental Health Telephone/Email Management Fee may be billed on the same day as the community patient conferencing fee (G14016) provided all other criteria are met, but the time spent with the patient on the telephone does not count toward the time requirement of the conferencing fee.

G14043 GP Mental Health Planning Fee $100.00

This fee is payable upon the development and documentation of a patient's Mental Health Plan for patients resident in the community (home or assisted living, excluding care facilities) with a confirmed Axis I diagnosis of sufficient severity and acuity to cause interference in activities of daily living and warrant the development of a management plan.

This fee requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, and use of appropriate validated assessment tools, with confirmation of diagnosis through DSM IV diagnostic criteria. It requires a face-to-face visit with the patient, with or without the patient's medical representative.

From these activities (review, assessment, planning and documentation) a Mental Health Plan for that patient will be developed that documents in the patient's chart:

- that there has been a detailed review of the patient's chart/history and current therapies;
- the patient's mental health status and provisional diagnosis by means of psychiatric history and mental state examination;
- the use of and results of validated assessment tools. GPSC strongly recommends that these evaluative tools, as clinically indicated, be kept in the patient's chart for immediate accessibility for subsequent review. Assessment tools such as the following are recommended, but other assessment tools that allow risk monitoring and progress of treatment are acceptable:

    i) PHQ9, Beck Inventory, Ham-D for depression;
    ii) MMSE for cognitive impairment;
    iii) MDQ for bipolar illness;
    iv) GAD-7 for anxiety;
    v) Suicide Risk Assessment;
    vi) Audit (Alcohol Use Disorders Identification Test) for Alcohol Misuse;

- DSM-IV Axis I confirmatory diagnostic criteria;
- a summary of the condition and a specific plan for that patient's care;
- an outline of expected outcomes;
- outlined linkages with other health care professionals (Including Community Mental Health Resources and Psychiatrists, as indicated and/or available) who will be involved in the patient's care, and their expected roles;
- an appropriate time frame for re-evaluation of the Mental Health Plan;
- that the developed plan has been communicated verbally or in writing to the patient and/or the patient's Medical Representative, and to other health professionals as indicated.

Notes:

i) Requires documentation of the patient's mental health status and diagnosis by means of psychiatric history, mental state examination, and confirmatory DSM IV diagnostic criteria. Confirmation of Axis I Diagnosis is required for patients eligible for the GP Mental Health Planning Fee. *Not intended for patients with self limiting or transient mental health symptoms (e.g. Brief situational adjustment reaction, normal grief, life transitions) for whom a plan for longer term mental health care is not necessary.*
ii) Payable once per calendar year per patient;
iii) Payable in addition to a visit fee billed same day;
iv) Minimum required time 30 minutes in addition to visit time same day;
v) G14016, community conferencing fee payable on same day for same patient, if all criteria met;
vi) Not payable on the same day as G14045, G14046, G14047, G14048 (GP Mental Health Management Fees);
vii) Not payable on the same day as G14049 (GP Mental Health Telephone/Email Management fee)
viii) Not intended as a routine annual fee if the patient does not require ongoing Mental Health Plan review and revision;
ix) G14015, Facility Patient Conferencing Fee, not payable on same day for same patient as facility patients are not eligible.

G14045 GP Mental Health Management	Fee age 2–59	$50.31
G14046 GP Mental Health Management	Fee age 60–69	$57.86
G14047 GP Mental Health Management	Fee age 70–79	$62.89
G14048 GP Mental Health Management	Fee age 80+	$65.41

These fees are payable for GP Mental Health Management required beyond the four MSP counselling fees (age-appropriate 00120 fees billable under the MSC payment schedule) for patients with a chronic mental health condition on whom a Mental Health Plan has been created and billed.

Notes:

i) Payable a maximum of 4 times per calendar year per patient;
ii) Payable only if the Mental Health Planning Fee (G14043) has been previously billed and paid in the same calendar year by the same physician;
iii) Payable only to the physician paid for the GP Mental Health Planning Fee (G14043), unless that physician has agreed to share care with another delegated physician;
iv) Not payable unless the age-appropriate 00120 series has been fully utilized;
v) Minimum time required is 20 minutes;
vi) Not payable on same day as G14043 (GP Mental Health Planning Fee), or G14049 (GP Mental Health Telephone/Email Management Fee);
vii) G14016 (Community Patient Conferencing Fee) payable on same day for same patient if all criteria met;
viii) G14015 (Facility Patient Conferencing Fee) not payable on same day as facility patients not eligible;
ix) CDM fees (G14050, G14051, G14052) payable if all criteria met.

G14049 GP Mental Health Telephone/Email Management Fee $15.00

This fee is payable for two-way communication with eligible patients via telephone or email for the provision of clinical follow-up management by the GP who has created and billed for the GP Mental Health Planning Fee (G14043). This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

i) Payable to a maximum of five times per calendar year per patient;

ii) Not payable unless the GP/FP is eligible for and has been paid for the GP Mental Health Planning Fee (G14043) during the same calendar year;

iii) Telephone/Email Management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not payable for simple notification of office appointments;

iv) Payable only to the physician paid for the GP Mental Health Planning Fee (G14043) unless that physician has agreed to share care with another delegated physician;

v) G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement for the G14016;

vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016;

vii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed;

Eligibility for G14043, G14045, G14046, G14047, G14048, G14049

- Eligible patients are community based, living in their home or assisted living. Facility based patients are <u>not</u> eligible.
- Payable only to the GP or practice group that accepts the role of being Most Responsible for the longitudinal, coordinated care of the patient for that calendar year;
- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months;
- Not payable to physicians who are employed by or who are under contract whose duties would otherwise include provision of this care;
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

Mental Health Frequently Asked Questions

1. What is the purpose of the Mental Health Initiative Fees?

Family Physicians provide the majority of mental care in BC. This is time consuming and is often not adequately compensated, so the Mental Health fees have been created to provide compensation for the provision of this care. Additionally, there is known benefit from having a longer planning visit with patients suffering from chronic mental health conditions and this initiative was developed to remove the financial barrier to providing this care, as opposed to seeing a greater number of patients with simpler clinical conditions.

This initiative is designed to focus on those patients with greater need and those that require more time of the community General Practitioner (GP), so the eligible patient population is restricted to patients living in the community (their own homes or assisted living) who:

- Have an Axis I diagnosis confirmed by DSM IV criteria, with
- Severity and Acuity level causing sufficient interference in activities of daily living that developing a management plan would be appropriate.

2. What is a Mental Health Plan?

The initial service allowing access to the mental health care fees shall be the development of a Mental Health Plan for a patient residing in his/her home or assisted living (excludes care facilities) with a diagnosed DSM IV Axis I mental health condition. This plan should be reviewed and revised as clinically indicated.

Creation of a Mental Health Plan requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, and use of appropriate validated assessment tools, with confirmation of diagnosis through DSM IV diagnostic criteria. It requires a face-to-face visit with the patient, with or without the patient's medical representative.

From these activities (review, assessment, planning and documentation) a Mental Health Plan for that patient will be developed that documents in the patient's chart:

- that there has been a detailed review of the patient's chart/history and current therapies;
- the patient's mental health status and provisional diagnosis by means of psychiatric history and mental state examination;
- the use of and results of validated assessment tools. GP Services Committee strongly recommends that these evaluative tools, as clinically indicated, be kept in the patient's chart for immediate accessibility for subsequent review. Assessment tools such as the following are recommended, but other assessment tools that allow risk monitoring and progress of treatment are acceptable:

i) PHQ9, Beck Inventory, Ham-D for depression;
ii) MMSE for cognitive impairment;
iii) MDQ for bipolar illness;
iv) GAD-7 for anxiety;
v) Suicide Risk Assessment;
v) Audit (Alcohol Use Disorders Identification Test) for Alcohol Misuse;

- DSM-IV Axis I confirmatory diagnostic criteria;
- a summary of the condition and a specific plan for that patient's care;
- an outline of expected outcomes;
- outlined linkages with other health care professionals (Including Community Mental Health Resources and Psychiatrists) as indicated and/or available) who will be involved in the patient's care, and their expected roles;
- an appropriate time frame for re-evaluation of the Mental Health Plan;
- that the developed plan has been communicated verbally or in writing to the patient and/or the patient's Medical Representative, and to other health professionals as indicated.

3. How do I bill the Mental Health Fees?

The first service must be the creation of a Mental Health Plan as described in Question 2 above. This acts as a "portal" to access the other Mental Health Management Fees. The GP Mental Health Planning Fee (G14043) may be billed once per calendar year per patient upon:

i) confirming that the patient is living in his/her own home or in assisted living;
ii) confirming through DSM IV criteria that the patient has an Axis I disorder;
iii) determining that the severity and acuity level of this Axis I disorder is causing sufficient interference in activities of daily living that developing a management plan to maintain the patient safely in the community would be appropriate, and
iv) creating a Mental Health Plan for that patient that includes all of the elements outlined in fee G14043 (See Question 2 above).

Note:

a. A visit fee code **MAY** accompany the billing for the GP Mental Health Planning Fee (G14043), but this is not a requirement. The first 30 minutes of time is the requirement of the GP Mental Health Planning Fee (G14043); additional time past the first 30 minutes counts towards the visit fee that may be billed in addition to G14043;
b. this visit may be a standard office or out-of-office visit, a CPx, home visit, or a Prolonged Counselling visit as appropriate;
c. Fee item G14043 **MUST** be dated the same date as the patient visit in which the Mental Health Plan was discussed/confirmed;
d. It is strongly recommended that your chart entry include the time spent in preparing the Mental Health Plan and, if a visit is also billed, the amount of time spent with the patient in addition to the minimum 30 minutes required to bill G14043;
e. Time spent on preparation of the Mental Health plan does not count towards the time requirement for a Prolonged Counselling visit.

4. Must I spend a single block of at least 30 minutes with the patient to bill the Mental Health Planning Fee (G14043)?

Unlike the Complex Care Fee, the Mental Health Planning Fee does require a minimum block of 30 consecutive minutes in face-to-face interaction with the patient. Provision of quality mental health care through assessment, development of a plan, and discussion with the patient and/or patient's medical representative does require more face-to-face time than a regular office visit.

A block of 30 minutes in face-to-face contact with the patient is therefore required to bill the GP Mental Health Planning Fee G14043. Time spent in addition to 30 minutes counts towards the visit fee that may be billed on the same day. It is strongly recommended that your chart entry include the time spent in preparing the Mental Health Plan and, if a visit is also billed, the amount of time spent with the patient in addition to the minimum 30 minutes required to bill G14043.

5. May I bill the Mental Health Planning Fee (G14043) on every patient I have with a qualifying diagnosis?

The fee requires **both**:

- a qualifying Axis I diagnosis, and
- that this diagnosis has "a Severity and Acuity level causing sufficient interference in activities of daily living that developing a management plan would be appropriate."

Many patients with an Axis I diagnosis are stable, or of a lower severity/acuity level so that extra time is not required to provide their care. It would not be appropriate to bill for these patients. The Mental Health Management Fee (G14043) is designed to remove the disincentive to providing the time to those qualifying patients who truly need it.

While it may be billed once in a calendar year, it is not intended to be an annual fee, as not all patients require a mental health plan each year; many people with depression remain stable or in remission for years. The need for a mental health plan would depend upon the acuity of the patient's condition.

Whether the patient needs an annual plan or not is left to your professional judgement and to trust. If the annual Mental Health Management Fee is billed for all Axis I patients, the GP Services Committee will have fewer funds to allocate for other areas requiring support.

6. When can I bill the Mental Health Management Fees (G14045-G14048)?

The MSP counselling fees (the 00120 series) are limited to four visits per patient per calendar year. Managing patients with a significant mental health diagnosis, however, may require more than four counselling visits per year. The GPSC Mental Health Management fees provide an additional four counselling visits per calendar year to provide counselling to these patients. They are payable only after all four MSP counselling fees of the 00120 series have been utilized and only if the GP has billed and been paid for the Mental Health Care Planning Fee. They are payable to a maximum of four times per calendar year, at the same rate as the age-appropriate 00120 series counselling fee.

Notes:

This fee is payable only if the GP or practice has billed and been paid for the Mental Health Planning Fee (G14043). ***(A note record is required if billed by another physician sharing care with the MRGP – see # 8 and #15 below.)***

i. These fees are payable only after the standard MSP 00120 series has been fully utilized;
ii. Payable to a maximum 4 times per year per patient.

7. When can I bill the Mental Health Telephone/Email Management Fee?

There is evidence that the follow-up of patients with significant mental illness does not always need to be face-to-face or by the physician. This new fee is payable for two-way clinical interaction provided between the GP or delegated practice staff (e.g. office RN or MOA) in follow-up on the Mental Health Planning Fee (G14043).

Notes:

i. Not payable unless the GP/FP is eligible for and has paid for the GP Mental Health Planning Fee (G14043) during the same calendar year;
ii. Telephone/Email Management requires 2-way communication between the patient and physician or medical office staff on a clinical level; it is not payable for simple notification of office appointments;
iii. Payable only to the physician paid for the GP Mental Health Planning Fee (G14043) unless that physician has agreed to share care with another delegated physician;
iv. Payable to a maximum of 5 times per calendar year per patient;

v. G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement for the G14016;
vi. Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016;
vii. Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed;

8. How would our group practice arrange to be able to 'share' these Mental Health Management Fees?

To make these fees as flexible as possible in the variety of practice styles found in the province, GPSC decided that no specific steps should need to be taken. We will become involved only if a GP who has billed and been paid for the 'portal' fee - the GP Mental Health Planning Fee (G14043) – lodges a complaint with GPSC. In that case, we will adjudicate based upon which GP has been paid for fee item G14043.

9. What is the difference between "assisted living" and "care facilities"?

There are a wide range of living facilities currently available. Some, referred to under the terms of this initiative as 'assisted living' facilities, provide only basic supports, such as meals and housecleaning, and are unable to provide their residents with nursing and other health support. A "care facility" on the other hand, is defined under the terms of this initiative as being a facility that does provide supervision and support from other health professionals such as nurses.

10. Why is this incentive limited to patients living in their homes or in assisted living?

While there may be exceptions, patients resident in a facility such as a Psychiatric Long Term Care Facility or hospital usually have available a resident team of other health care providers to share in the organization and provision of care. Patients residing in their homes or in assisted living usually do not have such a team, and the organization and supervision of care is usually more complex and time consuming for the GP.

11. Why are there restrictions excluding physicians "who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care" or to "physicians working under salary, service, or sessional arrangements?"

This incentive has been designed to remove the disincentive that exists under current fee for service payments to provide more time-consuming complex care to a patient, instead of choosing to see a greater number of patients of a simpler clinical nature. The physician's time is considered to be already compensated if he/she is under a contract "whose duties would otherwise include provision of this care", or is being compensated by a salary, service, or sessional arrangement.

12. Am I eligible to bill for the Community Patient Conferencing Fee (G14016) in addition to receiving the Mental Health Care payment(s)?

Yes. The mental health care payment(s) relates to services provided to the patient. The new "Mental Health Management Fees" (G14045-G14048) for non-face-to-face care still relates to the services provided to the patient. If it is appropriate for some of this care to be provided by phone, then the physician is compensated for this. If as a result of the Mental Health Planning

visit (G14043), follow up Mental Health Management visit (G14045-G14048) or as a result of the Mental Health Telephone/Email Management (G14049), the physician needs to conference with allied health professions about the care plan and any changes, then the services provided in conferencing with other health care professionals is payable over and above the mental health care payments. It is payable on the same day as long as all criteria are met. The time spent on the phone with the patient for the Mental Health Telephone/Email Management (G14049) does not count toward the total time billed under the Community Patient Conferencing Fee (G14016).

13. Am I eligible to bill for the Chronic Disease Management Fee(s) (G14050/G14051/G14052) in addition to these Mental Health Initiative fees?

Yes, patients with mental health diagnoses still often have co-existing medical conditions. For those patients with Diabetes and/or Congestive Heart Failure, the CDM payment(s) G14050/G14051 are payable in addition to the Mental Health Care payment(s). Additionally, if the patient does not have Diabetes and or CHF, but does have hypertension, the CDM payment for this (G14052) is payable in addition to the Mental Health Initiative payment(s). These are payable on the same day as long as all criteria are met.

14. Why is the Mental Health Telephone/Email Management Fee (G14049) restricted to the GP that has been paid for the Mental Health Planning Fee (G14043)?

This fee is designed to allow greater flexibility in providing follow-up to a plan that has been created. The GP that has been paid for the Mental Health Planning Fee has also accepted the responsibility of being Most Responsible for that patient's care for mental health diagnoses for that calendar year. The Mental Health Plan requires work, the shouldering of responsibility, and has considerable value. This fee is therefore restricted to the GP that has created the mental health plan.

15. If the GP Mental Health Management fees (G14045-G14048) and the GP Mental Health Telephone/Email Management fees (G14049) are restricted to the GP who has been paid for the Mental Health Planning Fee (G14043), what do group practices do when they share the care of the patient?

An exception has been made, allowing another GP to bill for this fee with the approval of the Most Responsible GP (MRGP). This allows flexibility in situations when patient care is shared between GPs. In this circumstance, the alternate GP must submit the claim with a note record indicating he/she is in the group of the MRGP and is sharing the care of the patient.

If a disagreement arises about the billing of this service, GP Services will adjudicate based upon whether the Most Responsible GP, i.e. the GP paid for the Annual Mental Health Planning Fee, approved or did not approve the service provided. GP Services feels that this provides the maximum flexibility while still maintaining responsibility.

16. Can I access the Mental Health Management fees if I have billed for the Mental Health Planning fee but have not yet been paid for it?

Adjudication of any billings for Mental Health Management fees will depend upon whether the GP is eventually paid for the Mental Health Care Planning Fee. In other words, if a GP bills for the Mental Health Planning Fee (G14043) and provides—and bills for— a follow-up Management service under G14045, G14046, G14047, G14048, or G14049 prior to receiving payment for G14043, payment for those follow-up Management billings will be made only if

G14043 is subsequently paid to that GP. Until that time any follow-up services will show as "BH" on the remittance.

The 2008 GPSC Approach to Mental Health is experimental

It is hoped that there will be greater participation in testing and supports for the care of this high-needs population.

It is understood that not all seriously mentally ill patients will be identified through this initiative.

GPSC will work closely with Family Physicians to ascertain the effectiveness of the incentive from the Patient, Provider, and System perspectives.

It is anticipated that payments or mental illness care will evolve with Family Physician input in subsequent years.

GPSC will review the utilization and efficacy of this initiative on an ongoing basis and may make revisions based upon its review

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COMPLEX CARE MANAGEMENT FEES
Revised January 1, 2008

The General Practice (GP) Services Committee has received considerable feedback expressing concerns about the structure of the original Complex Care Fee Options One and Two. Many GPs feel that it is too complex, and others have expressed concern that care provided subsequent to the Option Two annual block visit fee is not tracked and will not capture care provided.

In response to this feedback, the GP Services Committee has revised the Complex Care Fee, effective January 1, 2008. The revised fee combines the best elements of the initial two options to streamline billing and still appropriately compensate GPs for the management of these complex patients.

This fee item is designed to compensate GPs for the extra time required to provide planned care to more complex patients residing in their homes or in assisted living (excluding care facilities).

Under the revised Complex Care Management Fees, there is only one billing option for the planning and provision of care for eligible patients over the course of the calendar year:

- Fee Item G14033 provides compensation for the creation of a Complex Care Plan for eligible patients; those with two qualifying co-morbidities. This fee of $315 is payable once per calendar year for the provision and monitoring of the Complex Care Plan during that calendar year.

- Provision of care for eligible patients will be billed on a standard fee-for-service basis. Face-to-face visits between the GP and patient are required using the appropriate MSP fee code.

- Additionally, once a GP/FP or practice has determined a patient is eligible for a Complex Care Plan and has created and successfully billed for this plan, they may access a new Complex Care Follow-Up Management fee under Fee Item G14039. These fees compensate the GP/FP or practice for two-way telephone or email communication with the patient or the patient's medical representative. These fees are paid at $15 for up to a maximum of four services per calendar year.

Due to the time, intensity and complexity of creating the complex care plan, GPSC has determined that a maximum of five Complex Care Management Fees can be billed by a GP per calendar day. Upon application, an exemption may be granted by GPSC under some circumstances; e.g. GP/FPs electing to dedicate a half-day for practice meetings with Complex Care patients. These applications must be in writing and must include the specifics of the reasons for requesting an exemption.

The General Practitioner or practice group may bill these fees when providing care to patients residing in their homes or in assisted living with **any two** of the following chronic conditions:

- ***Diabetes mellitus (type 1 and 2)***
- ***Chronic renal failure with eGFR values less than 60***
- ***Congestive heart failure***
- ***Asthma***
- ***Chronic obstructive pulmonary disease (emphysema and chronic bronchitis)***
- ***Cerebrovascular disease***
- ***Ischemic heart disease, excluding the acute phase of myocardial infarct***

*Diagnostic codes have been developed to cover all combinations of any two of the following conditions - **refer to Table 1**.

These items are payable only to the General Practitioner or practice group that accepts the role of being Most Responsible for the longitudinal, coordinated care of that patient. By billing this fee the practitioner or practice accepts this responsibility for the ensuing calendar year.

These complex care fee items are:

- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months;
- Not payable to physicians who are employed by or who are under contract whose duties would otherwise include provision of this care;
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

G14033 – Annual Complex Care Management Fee **$315**

The Complex Care Management Fee is advance payment for the complexity of caring for patients with two of the eligible conditions and is payable upon the completion and documentation of the Complex Care Plan for the management of the complex care patient during that calendar year.

A complex care plan requires documentation of the following elements in the patient's chart that:

1) there has been a detailed review of the case/chart and of current therapies;
2) there has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Complex Care Management Fee is billed;
3) specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;
4) incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the complex care fee;
5) outlines expected outcomes as a result of this plan, including end-of-life issues when clinically appropriate;
6) outlines linkages with other health care professionals that would be involved in the care and their expected roles;
7) identifies an appropriate time frame for re-evaluation of the plan; and
8) confirms that the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved health professionals as indicated.

Notes:

i. Payable once per calendar year;
ii. Payable in addition to office visits, CPx, or home visits with patient on the same day, which must accompany billing;
iii. Visit or CPx fee to indicate face-to-face interaction with patient same day must accompany billing;
iv. G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met;
v. G14015, facility patient conferencing fee, not payable on the same day for the same patient, as facility patients not eligible;
vi. CDM fees G14050/G14051/G14052 payable on same day for same patient, if all other criteria met;
vii. Minimum required time 30 minutes in addition to visit time same day;
viii. Maximum of 5 complex care fees per day per physician unless exemption given;
ix. Not payable for patients seen in locations other than the office, home or assisted living residence where no professional staff on site.

G14039 – Complex Care Telephone/Email Follow-Up Management Fee **$15.00**

This fee is payable for follow-up management, via two-way telephone or email communication, of patients for whom a Complex Care Management Fee (G14033) has been paid. Access to this fee is restricted to the GP that has been paid for the Complex Care Management Fee (G14033) and is therefore Most Responsible GP (MRGP) for the care of that patient for the submitted chronic conditions for that calendar year. The only exception would be if the billing GP has the approval of the MRGP, and this must be documented as a note entry accompanying the billing. As with all clinical services, dates of services under this item should be documented in the patient record together with the name of the person who communicated with the patient or patient's medical representative as well as a brief notation on the content of the communication.

Notes:

i) Payable a maximum of four times per calendar year per patient;
ii) Not payable unless the GP/FP is eligible for and has been paid for the Annual Complex Care Management Fee (G14033) during the same calendar year;
iii) Telephone or e-mail management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not billable for simple notification of office appointments;
iv) Payable only to the physician that has successfully billed for the Annual Complex Care Management Fee (G14033) unless the billing physician has the approval of the GP responsible for the Annual Complex Care Management Fee (G14033) and a note entry is submitted indicating this;
v) G14016, Community Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement for the G14016;
vi) Not payable on the same calendar day as a visit fee by the same physician for the same patient.
vii) Chart entry requires the capture of the name of the person who communicated with the patient or patient's representative as well as capture of the elements of care discussed

HOW TO BILL

- Have a face-to-face visit with the eligible patient, and the patient's medical representative if appropriate;
- Review the patient's history/chart and create a Complex Care Plan including the elements itemized above, which is billable only on the day of a face-to-face visit;
- Over the rest of the calendar year, conduct a review of the Complex Care Plan and provide other follow ups as clinically indicated. Follow-up may be face-to-face or by telephone/e-mail as appropriate, with the appropriate fee being payable.

Step 1 Create a Complex Care Plan G14033 $315

The Complex Care Management Fee acknowledges that eligible patients require medical management that is more time intense and complex. This fee compensates the GP/FP for the creation of a clinical action plan for the patient as described above, and for the additional complexity of managing these patients for the calendar year in which the Complex Care Plan is billed.

The initial service allowing access shall be the development of a Complex Care Plan for a patient residing in their home or assisted living (excluding care facilities) with two or more of the above chronic conditions. This requires fulfillment of the itemized elements of service and documentation of these as specified in the fee item above.

Step 2 Provide Office Visit Follow-Up

GPSC received feedback that, under the previous Option Two, GPs were uncertain when to bill for a visit under a different diagnostic code and when to include the service in the care pre-paid with this option. Concern was also expressed that care being provided under Option Two was not being tracked by MSP and therefore the patient may not appear to be receiving their majority source of care from their doctor. Under this revised Complex Care Management Fee, the complexity is pre-paid when the planning visit is undertaken, but each and every visit for the rest of the year will be billable under the appropriate MSP fee and with the presenting complaint diagnostic code.

Step 3 Provide Follow-Up Telephone/Email Management G14039 $15

This new addition to the complex care fees allows for the provision of medical management through two-way telephone or e-mail communication with the patient and/or the patient's medical representatives. These non-face-to-face services are payable to a maximum of four times per calendar year. These services will also be applied toward the majority source of care calculation for these patients.

Step 4 Use the ICD9 codes listed in Table 1

Diagnostic codes have been developed to cover all combinations of any two of the chronic conditions covered under the complex care fees.

Table 1

ICD9 Code	Condition One	Condition Two
A414	Asthma	Ischemic Heart Disease
A428	Asthma	Congestive Heart Failure
A250	Asthma	Diabetes
A430	Asthma	Cerebrovascular Disease
A585	Asthma	Chronic Kidney Disease (Renal Failure)
A491	Asthma	COPD (with Emphysema, Chronic Bronchitis)
I428	Ischemic Heart Disease	Congestive Heart Failure
I250	Ischemic Heart Disease	Diabetes
I430	Ischemic Heart Disease	Cerebrovascular Disease
I585	Ischemic Heart Disease	Chronic Kidney Disease (Renal Failure)
I491	Ischemic Heart Disease	COPD (with Emphysema, Chronic Bronchitis)
H250	Congestive Heart Failure	Diabetes
H430	Congestive Heart Failure	Cerebrovascular Disease
H585	Congestive Heart Failure	Chronic Kidney Disease (Renal Failure)
H491	Congestive Heart Failure	COPD (with Emphysema, Chronic Bronchitis)
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease (Renal Failure)
D491	Diabetes	COPD (with Emphysema, Chronic Bronchitis)
C585	Cerebrovascular Disease	Chronic Kidney Disease (Renal Failure)
C491	Cerebrovascular Disease	COPD (with Emphysema, Chronic Bronchitis)
R491	Chronic Kidney Disease (Renal Failure)	COPD (with Emphysema, Chronic Bronchitis)

Frequently Asked Questions:

1. What is the purpose of the Complex Care Management Fees?

The Complex Care Management Fees have been created to provide recognition that patients with co-morbid conditions require more time and effort to provide quality care, and to remove the financial barrier to providing this care as opposed to seeing more patients of a simpler clinical condition.

2. What is a Complex Care Plan?

The initial service allowing "portal" access to the complex care fees shall be the development of a Complex Care Plan for a patient residing in their home or assisted living (excluding care facilities) with two or more of the above chronic conditions. This plan should be reviewed and revised as clinically indicated. It is essentially an expansion of the SOAP formula for chart documentation.

A complex care plan requires documentation in the patient's chart that:

- there has been a detailed review of the case/chart and of current therapies;
- there has been a face-to-face visit with the patient or the patient's medical representative if appropriate, on the same calendar day that the Complex Care Management Fee is billed;
- specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;
- incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the Complex Care Management Fee;
- outlines expected outcomes as a result of this plan, including end-of-life issues when clinically appropriate;
- outlines linkages with other health care professionals that would be involved in the care and their expected roles;
- identifies an appropriate time frame for re-evaluation of the plan;
- confirms that the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved health professionals as indicated.

3. Why was the Complex Care fee changed?

The GP Services Committee received significant feedback that the original two options for billing the Complex Care fee were too complicated. Several concerns have been addressed by combining the two original fees:

Option One Complaints

1. This fee option has been difficult to track;
2. Physicians were uncertain when to bill the minor care plan review (G14031) vs. the follow up fees (G14032).
3. While phone or e-mail management was an option included in the Option Two block care payment, any phone or e-mail management under Option One was not billable.

With this revision, the complexity aspect of care is payable under a single fee, once per year, at the time of the major care planning visit. In addition, the new follow-up fee provides access to non-face-to-face compensation for all complex care patients.

Option Two Complaints

1. It has been confusing as to whether visits were or were not included in the pre-paid annual block visit fee if other matters were discussed:
2. Physicians expressed concern that care they provided to these patients that did not generate any billing would not be recognized in the calculation of "Majority Source of Care" patients, as there was no electronic indication that the care was actually provided;
3. There has been discomfort about accepting a pre-paid amount equivalent to six office visits as full annual payment for the two qualifying conditions.

With this revision, all services provided will be included in the Majority Source of Care calculations, including the new non-face-to-face follow-up fees, care provided by two-way phone or e-mail communication with eligible patients or their medical representatives.

With this revision, visit fees revert to standard Fee-for-Service, so each visit is compensable and, in addition, compensation is provided for non face-to-face two-way interaction with patients or their medical representatives.

4. How do I bill the new Complex Care Fees?

The first service must be the creation of a Complex Care Plan (see Question 2 above for details) in consultation with your eligible patient. You may then bill fee code 14033 (Annual Complex Care Management Fee) as well as the appropriate visit fee. The visit fee can be a standard in-office or out-of-office visit, a CPx, home visit, or prolonged counselling visit as appropriate
Note:

a. A visit fee code **MUST** accompany the billing for the Annual Complex Care Management Fee (G14033)
b. Fee item G14033 **MUST** be dated the same date of service as the date of the patient visit in which the Complex Care Plan was discussed.
c. It is strongly recommended that your chart entry include the time spent in preparing the Complex Care Plan and, if a Prolonged Counselling visit is billed, the time spent on the face-to-face visit;
d. Time spent on preparation of the Complex Care plan does not count towards the time requirement for a prolonged counselling visit

5. Must I spend at least 30 minutes with the patient to bill the Annual Complex Care Management Fee?

The complex care fee compensates for the time taken to review the chart, prepare a preliminary plan, discuss and finalize the plan with a face-to-face visit with the patient and/or the patient's medical representative, and to document the plan. It does not have to be done as a single 30-minute block, but as an aggregate amount of time spent. In most cases, GPs are reviewing the charts in advance, then meeting with the patient and/or representative, then subsequent to the meeting preparing the documentation of the final plan. It is strongly recommended, however, that your chart record include the time that has been spent in this process.

Note: As in Question 4 above, the date of service for the Annual Complex Care Management Fee **MUST** be the same as the date of service for the office visit in which the plan was discussed and finalized with the patient.

6. What is the difference between "assisted living" and "care facilities"?

There are a wide range of living facilities currently available. Some, referred to under the terms of this initiative as 'assisted living' facilities, provide only basic supports such as meals and housecleaning, and do not provide their residents with nursing and other health support.

A "care facility" on the other hand, is defined under the terms of this initiative as being a facility that does provide supervision and support from other health professionals such as nurses.

7. Why is this incentive limited to patients living in their homes or assisted living?

While there may be exceptions, patients residing in a Long Term Care Facility or hospital usually have a resident team of health care providers available to share in the organization and provision of care. Patients residing in their homes or in assisted living usually do not have such a team, so the organization and supervision of care is usually more complex and time consuming for the GP.

8. Why are there restrictions excluding physicians "who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care" or to "physicians working under salary, service, or sessional arrangements?"

The current Fee-for-Service payment schedule tends to encourage the provision of a higher volume of easier services as opposed to fewer, more complex and time-intensive services. This incentive has been designed to offset this disincentive.

If a physician is already compensated for providing these services through terms of employment, or through time-neutral payments such as salary, service, or sessional arrangements, their time is considered to be already compensated.

9. There are many co-morbidities that result in complexity of care. Why is this incentive limited to a list of seven conditions?

According to Ministry of Health data, patients living with two or more of the eligible conditions are among the most chronically ill in the province and high users of the acute care system. As a trial, the GP Services Committee has elected to introduce incentives on a smaller scale. As this revision shows, they can and will be modified depending upon the outcomes the incentive creates.

Compiling the list of eligible conditions has been a difficult task, and it has required a careful balance. It is apparent that many additional conditions create complexities in providing care, but at the same time, the 2006 Letter of Agreement stipulated a budget for all the activities of the GP Services Committee and requires that the GP Services Committee remain within that budget.

10. My software only captures one diagnostic code per billing. How do I indicate that the patient has two?

This has been a problem. While Teleplan requires that eligible software has the ability to enter more than one diagnostic code, many versions of software currently used do not support this. Also, vendors are currently so occupied with the Physician Information Technology Office (PITO) qualification process that we cannot realistically expect them to modify current versions.

To get around this barrier without requiring that many GPs modify their current software, the GP Services Committee created a number of different diagnostic codes to indicate different combinations of two eligible criteria.

11. What do I do if my patient has more than two of the eligible conditions?

Choose which two of the patient's eligible conditions to submit. Review the list of diagnostic codes provided and choose the one that reflects the two eligible conditions you wish to submit. Since the revised Complex Care payment involves the advance payment for the planning and "complexity" of the complex care conditions, but the care provided is billable on a fee-for-services basis, all patient care services are compensated as they occur regardless of the diagnoses.

12. Am I eligible to bill for the Community Patient Conferencing Fee (G14016) in addition to receiving the Complex Care Management payment(s)?

Yes. If the physician needs to conference with allied health professions about the care plan and any changes, then the services provided in conferencing with other health care professionals is payable over and above the Complex Care Management Payments, provided that all criteria for the Conferencing fee are met. The time spent on the phone or e-mail with the patient for the non-face-to-face complex care management does not count toward the total time billed under the community patient conferencing fee.

13. What is the difference between the Complex Care Telephone/Email Follow-Up Management Fee (G14039) and the Community Patient Conferencing Fee (G14016)?

The Complex Care Follow-Up Telephone/Email Management payment relates to services provided to the patient or the patient's medical representative as indicated. The Community Patient Conferencing Fee relates to services spent conferencing with other health care providers in a two-way discussion on the provision of care to benefit the patient.

14. Am I eligible to bill for the Chronic Disease Management Fee(s) (G14050/G14051/G14052) in addition to receiving the Complex Care payment(s)?

Yes. The Chronic Disease Management Fees (G14050, G14051, G14052) are independent of the Complex Care fees, and are payable on the same patient as long as the criteria for those fees are met.

15. Why is the Complex Care Telephone/Email Follow-Up Management Fee (G14039) restricted to the GP that has been paid for the Annual Complex Care Fee (G14033)?

This fee is designed to allow greater flexibility in providing follow-up to a plan that has been created. The GP that has been paid for the Annual Complex Care Management Fee has also accepted the responsibility of being the MRGP for that patient's care for the two submitted chronic illnesses for that calendar year. The Annual Complex Care Management Plan requires work, the shouldering of responsibility, and the co-ordination of care. It has considerable value. This fee is therefore restricted to the GP that has created the clinical action plan.

16. If the Complex Care Telephone/Email Follow-Up Management Fee is restricted to the GP who has been paid for the Annual Complex Care Management Fee, what do group practices do when they share the care of the patient?

An exception has been made, allowing another GP to bill for this fee with the approval of the MRGP. This allows flexibility in situations when patient care is shared between GPs. In this circumstance, the alternate GP must submit the claim with a note record indicating he/she is in the group of the MRGP and is sharing the care of the patient.

If a disagreement arises about the billing of this service, the GP Services Committee will adjudicate based upon whether the MRGP, i.e the GP paid for the Annual Complex Care Fee, approved or did not approve the service provided. The GP Services Committee feels that this provides the maximum flexibility while still maintaining responsibility.

17. Can I bill the Follow-up Management fees if I have billed for the Annual Complex Care Fee, but have not yet been paid?

Adjudication of this will depend upon whether the GP is eventually paid for the Annual Complex Care Fee. In other words, if a GP bills the Annual Complex Care Management Fee (G14033) then provides—and bills for—a follow-up service under G14039 prior to receiving payment for G14033, payment for G14039 will be made only if G14033 is subsequently paid to that GP. Until that time it will show as "BH' on the remittance.

Complex Care Billing Comparison Options One/Two with new Single Option

Mrs. J. is a 68 year old lady with diabetes and asthma. She has made an appointment to see you in January 2008 for her major annual review of her care plan that was set up the previous year. You review her medications and most recent lab tests as well as her peak flow chart. After also checking her diabetes flow sheet, you discuss with her the complex care plan for the remainder of the year and set up an appointment for her to have her complete check up in March when it is due.

In February, Mrs. J. calls when you are on call to advise that her peak flow has suddenly dropped into her low yellow zone after visiting her daughter who has a cat. She tells you that her maintenance dose of Flovent has been 125 mcg twice daily, so you ask her to increase to 250 mcg twice daily and to come in to the office to see you the following day. When you see her, you determine she has had a flare of her asthma but that there is no sign of acute infection, and so advise to continue with the increased Flovent. You see her again three days later and her peak flows have improved. You advise her to stay on this higher dose for the next two weeks, and that you will have your office nurse call to check on her.

When contacted in early March, her peak flows have stayed stable and she is advised to go back to her maintenance dose. You see her again in March for her CPX and over the rest of the year for follow up of her complex conditions She is seen in July, October and December twice due to a flare of her asthma. In addition, in September, she is seen by you for a bladder infection and treated appropriately. Mrs. J's Diagnostic Code for her Complex Care Management under all options is A250.

The billing comparisons of the original Options One and Two and the new Single Option are:

Month	Service	Option One		Option Two		Revised Single Option	
Jan	Major Complex Care Planning Visit	14030 16100	$100.00 $32.08	14033 13136	$315.00 $192.48	14033 16100	$315.00 $32.08
Feb	Phone call Complex Care Office Visit Complex Care Office visit	N/C 14032 16100 14032 16100	 $35.00 $32.08 $35.00 $32.08	N/C N/C N/C		14039 16100 16100	$15.00 $32.08 $32.08
March	Phone call CPX	N/C 16101	 $71.34	N/C 16101	 $71.34	14039 16101	$15.00 $71.34
July	Complex Care Office Visit	14032 16100	$35.00 $32.08	N/C		16100	$32.08
Sept	UTI Office Visit	16100 15130	$32.08 $1.96	16100 15130	$32.08 $1.96	16100 15130	$32.08 $1.96
Oct	Complex Care Office Visit – Minor Care Plan review	14031 16100	$75.00 $32.08	N/C		16100	$32.08
Dec	Complex Care Office Visit Office visit for asthma flare	14032 16100 16100	$35.00 $32.08 $32.08	N/C N/C		16100 16100	$32.08 $32.08
Total		**$644.94**		**$612.86**		**$674.94**	